University of Alberta

Attitudes and Behaviours of Alberta Mental Health Nurses Toward Professional Boundaries, Boundary Crossings, and Boundary Violations in Patient Care

by

R. Joan Campbell ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

Faculty of Nursing

Edmonton, Alberta

Spring 2002

National Library
of Canada

Acquisitions and
Bibliographic Services

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque nationale
du Canada

Acquisitions et
services bibliographiques

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-69670-7

Canadä

University of Alberta

Library Release Form

Name of Author:	R. Joan Campbell
Title of Thesis:	Attitudes and Behaviours of Alberta Mental Health Nurses Toward Professional Boundaries, Boundary Crossings, and Boundary Violations in Patient Care
Degree:	Master of Nursing
Year This Degree Granted:	2002

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly, or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the thesis, and except as herein provided, neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

R. Joan Campbell

21 Gravenhurst Crescent
Sherwood Park, Alberta
T8A 3C3

January 29, 2002

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Attitudes and Behaviours of Alberta Mental Health Nurses Toward Professional Boundaries, Boundary Crossings, and Boundary Violations in Patient Care** submitted by R. Joan Campbell in partial fulfillment of the requirements for the degree of Master of Nursing.

Olive Yonge
Dr. Olive Yonge, Supervisor

Wendy Austin
Dr. Wendy Austin

A. Brian Nielsen
Dr. Brian Nielsen

January, 11, 2002

Abstract

A descriptive survey of the entire Alberta population of mental health nurses was carried out in the spring of 2000 to determine the attitudes and behaviours of mental health nurses concerning (a) professional boundary knowledge, (b) gift giving, (c) personal disclosure, (d) confidentiality and secrecy, (e) personal space, (f) dual relationships and sexual misconduct, and (g) nurse-patient relationships. A response rate of 46% was obtained. The findings indicated that group therapy and forensic nurses were the least likely to engage in boundary crossings and violations, whereas geriatric and child and adolescent nurses were the most likely. Registered Psychiatric Nurses tended to commit the most serious boundary violations. The results of the study identified that mental health nurses require additional education and training regarding boundary theory, personal and professional boundaries, boundary crossings, and boundary violations. Further research is required to develop and advance boundary theory within the nurse-patient relationship.

Acknowledgements

Joan Campbell gratefully acknowledges the following individuals and organizations for their continued interest, assistance, and support during the development and implementation of this research project:

Dr. Olive Yonge, Thesis Supervisor
Dr. Wendy Austin, Thesis Committee Member
Dr. Brian Nielsen, Thesis Committee Member
Faculty of Nursing, University of Alberta
Caritas Research Steering Committee
Grey Nuns Community Hospital, Mental Health Program
    Barb Richard, Clinical Nurse Educator
    Maryanne Embury, Secretary III
Grey Nuns Community Hospital, Library Services
    Sheila Fynn, Library Technician
    Val Westberg, Library Clerk
    Normita Coralejo, Library Clerk

Table of Contents

Page

CHAPTER ONE INTRODUCTION 1

Background 1

Statement of Purpose and Research Questions 5

Definition of Terms 6

CHAPTER TWO LITERATURE REVIEW 8

Introduction 8

Nurse-Patient Relationship 8

Power, Transference, and Countertransference 10

Boundary Theory 12

Personal Boundaries 12

Professional Boundaries 15

Boundary Crossings 17

Gift Giving 17

Personal Disclosure 18

Boundary Violations 20

Dual Relationships 22

Sexual Misconduct 24

Effects of Sexual Intimacy 28

Educator-Student Boundary Violations and Sexual Intimacy 29

Demographic Studies 30

Therapist-Patient Sexual Intimacy 34

Demographic Studies 35

Medicine 35

Psychology 37

Social Work 40

Nursing 42

Joint Studies 44

Conclusion 45

Research Questions and Assumptions 45

CHAPTER THREE METHODS AND PROCEDURES 49

Survey Research Design 49

Target Population and Sample 49

Data Collection Strategies 50

Data Analysis 50

Ethical Considerations 51

Strengths and Weaknesses of the Design 52

Reliability and Validity of Measures 53

CHAPTER FOUR RESULTS 55

Description of the Respondents 56

Participant Demographic Profile 56

Education 56

Gender, Age, and Marital Status 57

Participant Work History 58

Years Working in Mental Health Nursing 58

Place and Location of Employment 58

Clinical Area 59

Position Title, Position Type, and Amount of Time Worked.........60

Knowledge of Professional Boundaries.........61

Attitudes Toward the Importance of Professional Boundaries.........61

Professional Boundary Education.........66

Interest in Increasing Professional Boundary Knowledge.........77

Boundary Crossings.........79

Gift Giving.........79

Gift-Giving Attitudes.........80

Gift-Giving Attitudes.........80

Analysis of Variance for Gift-Giving Attitudes by Age.........82

Gift-Giving Behaviours.........93

Gift-Giving Behaviours.........94

Personal Disclosure.........107

Attitudes Toward Personal Disclosure.........107

Behaviours and Personal Disclosure.........123

Confidentiality and Secrecy.........140

Attitudes Toward Confidentiality and Secrecy.........141

Behaviours Around Secrecy and Keeping Confidences.........152

Personal Space.........161

Personal Space Attitudes.........162

Personal Space Behaviours.........174

Boundary Violations.........184

Dual Relationships and Sexual Misconduct.........184

Attitudes Toward Dual Relationships and Sexual Misconduct...185

Behaviours Around Dual Relationships and Sexual Misconduct 206

Nurse-Patient Relationships 235

Attitudes and Behaviours Around Nurse-Patient Relationships.238

Summary..........250

Professional Boundary Knowledge 250

Professional Boundary Education..........252

Interest in Increasing Professional Boundary Knowledge..........255

Gift-Giving..........257

Personal Disclosure..........263

Confidentiality and Secrecy 270

Personal Space 274

Dual Relationships and Sexual Misconduct..........281

Nurse-Patient Relationships 293

CHAPTER FIVE DISCUSSION 296

Knowledge of Professional Boundaries..........297

Attitudes Toward the Importance of Professional Boundaries 297

Professional Boundary Education..........298

Interest in Increasing Professional Boundary Knowledge..........299

Boundary Crossings..........300

Gift Giving..........300

Personal Disclosure..........302

Confidentiality and Secrecy 304

Personal Space 305

Boundary Violations 306

Dual Relationships and Sexual Misconduct....................................306

Nurse-Patient Relationships 309

Summary...309

Limitations...311

Implications for Further Research 312

Conclusion 313

REFERENCES 315

APPENDIX A FREQUENCY STUDIES OF SEXUAL INTIMACY 327

APPENDIX B PARTICIPANT DEMOGRAPHIC PROFILE 329

APPENDIX C PARTICIPANT WORK HISTORY 331

APPENDIX D CLINICAL AREAS 333

APPENDIX E POSITION TITLE, POSITION TYPE, AND AMOUNT OF TIME WORKED..335

APPENDIX F SURVEY INSTRUMENT 337

List of Tables

Page

Table 1 Importance of Professional Boundaries 62

Table 2 Professional Boundary Education 68

Table 3 Interest in Increasing Professional Boundary Knowledge 78

Table 4 Gift-Giving Attitudes 80

Table 5 Analysis of Variance for Gift-Giving Attitudes by Age 82

Table 6 Analysis of Variance for Gift-Giving Attitudes by Gender 84

Table 7 Analysis of Variance for Gift-Giving Attitudes by Nursing Education 86

Table 8 Analysis of Variance for Gift-Giving Attitudes by Years of Experience 87

Table 9 Analysis of Variance for Gift-Giving Attitudes by Specialty Area 89

Table 10 Analysis of Variance for Gift-Giving Attitudes by Current Work Area 91

Table 11 Analysis of Variance for Gift-Giving Attitudes by Workplace Location 92

Table 12 Gift-Giving Behaviours 94

Table 13 Analysis of Variance for Gift-Giving Behaviours by Gender 96

Table 14 Analysis of Variance for Gift-Giving Behaviours by Nursing Education 98

Table 15 Analysis of Variance for Gift-Giving Behaviours by Years of Experience 99

Table 16 Analysis of Variance for Gift-Giving Behaviours by Specialty Area 101

Table 17 Analysis of Variance for Gift-Giving Behaviours by Current Work Area 103

Table 18 Analysis of Variance for Gift-Giving Behaviours by Workplace Location 104

Page

Table 19 Analysis of Variance for Gift-Giving Behaviours by Amount of Time Worked 105

Table 20 Attitudes Toward Personal Disclosure 108

Table 21 Analysis of Variance for Attitudes Toward Personal Disclosure by Age 111

Table 22 Analysis of Variance for Attitudes Toward Personal Disclosure by Gender 112

Table 23 Analysis of Variance for Attitudes Toward Personal Disclosure by Nursing Education 114

Table 24 Analysis of Variance for Attitudes Toward Personal Disclosure by Years of Experience 115

Table 25 Analysis of Variance for Attitudes Toward Personal Disclosure by Specialty Area 117

Table 26 Analysis of Variance for Attitudes Toward Personal Disclosure by Current Work Area 119

Table 27 Analysis of Variance for Attitudes Toward Personal Disclosure by Workplace Location 121

Table 28 Analysis of Variance for Attitudes Toward Personal Disclosure by Amount of Time Worked 122

Table 29 Behaviours Around Personal Disclosure 124

Table 30 Analysis of Variance for Behaviours Around Personal Disclosure by Age 126

Table 31 Analysis of Variance for Behaviours Around Personal Disclosure by Gender 128

Table 32 Analysis of Variance for Behaviours Around Personal Disclosure by Nursing Education 129

Table 33 Analysis of Variance for Behaviours Around Personal Disclosure by Years of Experience 131

Table 34 Analysis of Variance for Behaviours Around Personal Disclosure by Specialty Area 133

Page

Table 35 Analysis of Variance for Behaviours Around Personal Disclosure by Current Work Area 135

Table 36 Analysis of Variance for Behaviours Around Personal Disclosure by Workplace Location 137

Table 37 Analysis of Variance for Behaviours Around Personal Disclosure by Amount of Time Worked 138

Table 38 Attitudes Toward Secrecy and Keeping Confidences 142

Table 39 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Age 143

Table 40 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Gender 144

Table 41 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Nursing Education 146

Table 42 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Specialty Area 148

Table 43 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Current Work Area 150

Table 44 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Workplace Location 151

Table 45 Behaviours Around Secrecy and Keeping Confidences 153

Table 46 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Age 155

Table 47 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Gender 156

Table 48 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Current Work Area 158

Table 49 Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Workplace Location 159

Table 50 Attitudes Toward Personal Space 162

Table 51 Analysis of Variance for Attitudes Toward Personal Space by Age 164

Page

Table 52 Analysis of Variance for Attitudes Toward Personal Space by Gender 165

Table 53 Analysis of Variance for Attitudes Toward Personal Space by Years of Experience 167

Table 54 Analysis of Variance for Attitudes Toward Personal Space by Specialty Area 169

Table 55 Analysis of Variance for Attitudes Toward Personal Space by Current Work Area 171

Table 56 Analysis of Variance for Attitudes Toward Personal Space by Workplace Location 172

Table 57 Analysis of Variance for Attitudes Toward Personal Space by Amount of Time Worked 173

Table 58 Behaviours Around Personal Space 174

Table 59 Analysis of Variance for Behaviours Around Personal Space by Nursing Education 176

Table 60 Analysis of Variance for Behaviours Around Personal Space by Specialty Area 179

Table 61 Analysis of Variance for Behaviours Around Personal Space by Current Work Area 181

Table 62 Analysis of Variance for Behaviours Around Personal Space by Workplace Location 182

Table 63 Attitudes Toward Dual Relationships and Sexual Misconduct 187

Table 64 Analysis of Variance for Attitudes Toward Dual Relationships and Sexual Misconduct by Gender 191

Table 65 Analysis of Variance for Attitudes Toward Dual Relationships and Sexual Misconduct by Nursing Education 194

Table 66 Analysis of Variance for Attitudes Toward Dual Relationships and Sexual Misconduct by Specialty Area 197

Table 67 Analysis of Variance for Attitudes Toward Dual Relationships and Sexual Misconduct by Current Work Area 200

Page

Table 68 Analysis of Variance for Attitudes Toward Dual Relationships and Sexual Misconduct by Workplace Location....203

Table 69 Analysis of Variance for Attitudes Toward Dual Relationships and Sexual Misconduct by Amount of Time Worked....205

Table 70 Behaviours Around Dual Relationships and Sexual Misconduct....207

Table 71 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Age....212

Table 72 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Gender....215

Table 73 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Marital Status....217

Table 74 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Nursing Education....220

Table 75 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Years of Experience....222

Table 76 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Specialty Area....225

Table 77 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Current Work Area....228

Table 78 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Workplace Location....231

Table 79 Analysis of Variance for Behaviours Around Dual Relationships and Sexual Misconduct by Amount of Time Worked....233

Table 80 Attitudes and Behaviours Around Nurse-Patient Relationships....237

Table 81 Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Age....239

Page

Table 82 Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Gender 241

Table 83 Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Nursing Education 243

Table 84 Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Years of Experience 244

Table 85 Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Specialty Area 246

Table 86 Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Current Work Area 248

Table 87 Summary of the Significant ANOVA Results for the Importance of Professional Boundary Knowledge........................251

Table 88 Summary of the Significant ANOVA Results for Specific Types of Professional Boundary Education.................................256

Table 89 Summary of the Significant ANOVA Results for Gift-Giving Attitudes 262

Table 90 Summary of the Significant ANOVA Results for Gift-Giving Behaviours 263

Table 91 Summary of the Significant ANOVA Results for Attitudes Toward Personal Disclosure..268

Table 92 Summary of the Significant ANOVA Results for Behaviours Around Personal Disclosure..269

Table 93 Summary of the Significant ANOVA Results for Attitudes Toward Confidentiality and Secrecy 273

Table 94 Summary of the Significant ANOVA Results for Behaviours Around Confidentiality and Secrecy 274

Table 95 Summary of the Significant ANOVA Results for Personal Space Attitudes 279

Table 96 Summary of the Significant ANOVA Results for Personal Space Behaviours 280

Page

Table 97 Summary of the Significant ANOVA Results for Attitudes Toward Dual Relationships and Sexual Misconduct....................291

Table 98 Summary of the Significant ANOVA Results for Behaviours Around Dual Relationships and Sexual Misconduct....................292

Table 99 Summary of the Significant ANOVA Results for Attitudes and Behaviours Around Nurse-Patient Relationships..................295

CHAPTER ONE

INTRODUCTION

Background

Mental health professionals interacting with patients and clients must find the right balance between empathic understanding and objectivity (Epstein, Simon, & Kay, 1992; Sloane, 1993; Stone, 1975). Limits or boundaries between the therapist and the patient allow the maintenance of an appropriate distance that promotes both the independence of the patient and the ability of the therapist to remain emotionally separate (Backlar, 1996; Stone, 1975). An interaction between therapist and patient occurs on a continuum ranging from an excessively formal and remote relationship at one end to extreme overinvolvement resulting in intimate sexual relations at the other. The professional must find the appropriate middle ground in order to assist the patient in reaching therapeutic treatment goals.

It is the ethical obligation of all health care professionals to avoid harming the patients in their care. Prior to the 1970s and 1980s, sexual misconduct by health care professionals in North America was often treated with an attitude of tolerance (Appelbaum, 1990; Epstein, 1994; Schoener, 1996; Zelen, 1985), or even recommended as a therapeutic treatment (McCartney, 1966; Reich, 1949; Shepard, 1971). The obligation to avoid sexual intimacy with patients was first delineated more than 2,600 years ago by the mandate against seductive behaviour that is included in the Hippocratic Oath (Dahlberg, 1970; Edelstein, 1943; Kardener, 1974; Kardener, Fuller, & Mensh, 1973; Levine, 1972; Simon, 1988; Stone, 1975). Freud, the father of psychoanalysis, was also aware of the dangers of psychotherapists becoming sexually involved with patients (Appelbaum, 1990; Freud, 1958). He advised that transference love could be an outcome of the therapeutic situation and that the therapist should not "derive any personal advantage from it" (p. 169). Freud also cautioned that the "treatment must be carried out in abstinence" (p. 165) so that the patient's basic impulses might be brought to awareness.

Sexual misconduct has become one of the chief sources of malpractice litigation against professionals, and a number of states in the United States have criminalized therapist-patient sexual contact (Appelbaum, 1990; Gabbard & Menninger, 1991; Goisman & Gutheil, 1992; Gutheil & Gabbard, 1992; Simon, 1988; Vinson, 1987). However, it was not until 1973 that the American Psychiatric Association first prohibited sexual contact with current patients and in 1986 adopted an amendment to its ethical annotations indicating that sex with former patients was almost always unethical as well (American Psychiatric Association, 1986). The concerns about sexual exploitation by physicians have been addressed by some of the provincial Colleges of Physicians and Surgeons in Canada through major task force reports: British Columbia (Committee on Physician Sexual Misconduct, 1992), Alberta (College of Physicians and Surgeons of Alberta, 1992), and Ontario (College of Physician and Surgeons of Ontario, 1991). Similarly, in 1977 the American Psychological Association first specifically prohibited sexual intimacy with patients (Pope, 1987), and in 1987 took the position that it was also unethical to have any type of sexual relationship with a patient (current or former) under any condition, time, or place (Brown, 1988). The National Association of Social Workers (NASW) in 1993 also confirmed that "the social worker should under no circumstances engage in sexual activities with clients" (p. 5).

Most health care professionals now believe that sexual involvement with patients is unethical (Appelbaum, 1990; Brown, 1988; Feldman-Summers & Jones, 1984; Kagle & Giebelhausen, 1994; Schoener & Luepker, 1996), demoralizes and destroys the treatment process, and is harmful to both the patient and the professional (Apfel & Simon, 1985; Appelbaum, 1990; Blackshaw & Patterson, 1992; Epstein & Simon, 1990; Epstein et al., 1992; Frick, McCartney, & Lazarus, 1995; Gabbard, 1991; Gallop, 1993; Gutheil, 1989; Gutheil & Gabbard, 1992; Kagle & Giebelhausen, 1994; Pennington, Gafner, Schilit, & Bechtel, 1993; Simon, 1991). Sexual contact with patients following the completion of treatment is considered by many health professionals to be unethical as well (Epstein & Simon, 1990; Gutheil, 1989). The sexual involvement of a professional with a client tends to follow a predictable course of progressive nonsexual treatment boundary violations, with less serious forms of boundary violations preceding sexual impropriety (Coleman & Schaefer, 1986; Epstein, 1994; Folman, 1991; Gutheil & Gabbard, 1993; Kagle & Giebelhausen, 1994; Pope & Bouhoutsos, 1986; Simon, 1989, 1991, 1995; Strasburger, Jorgenson, & Sutherland, 1992; Wysoker, 2000).

It is important to note that not all boundary crossings and violations lead to sexual misconduct (Donen & Etkin, 1997; Gallop, 1998; Gutheil & Gabbard, 1993, 1998; Patterson & Blackshaw, 1993; Wysoker, 2000). However, nonsexual boundary crossings and violations may also cause significant harm to the patient (Borys & Pope, 1989; Brownlee, 1996; Epstein, 1994; Gabbard & Nadelson, 1995; Gutheil, 1994; Gutheil & Gabbard, 1998; Kagle & Giebelhausen, 1994; Pennington et al., 1993; Ramsdell & Ramsdell, 1994; Simon, 1991, 1992, 1995). The needs of the client must take priority over the needs of the professional, and delineating the boundaries in treatment is clearly the responsibility of the professional (Baron, 2001; Donen & Etkin, 1997; Epstein, 1994; Folman, 1991; Gallop, 1998; Norman, 2000; Patterson & Blackshaw, 1993; Simon, 1991,1992; Smith, Taylor, Keys, & Gornto, 1997).

Alternatively, Lazarus (1994) believed that well-intentioned ethical guidelines have been increasingly transformed into artificial boundaries that serve as harmful restrictions that weaken clinical effectiveness. He concluded that therapeutic effectiveness decreases when predetermined risk-management techniques and rigid rules of conduct take precedence over flexibility and inventiveness. In response to Lazarus's discourse, a number of clinicians have agreed that competent therapists must use clinical judgement rather than relying on fixed rules and regulations when providing clinical treatment to patients (Bennett, Bricklin, & VandeCreek; 1994; Brown, 1994; Gabbard, 1994). Nevertheless, these clinicians also believed in the importance of respecting boundary issues in therapy, recognizing boundary prohibitions, and eschewing the abusive use of power in the therapist-patient relationship.

Statement of Purpose and Research Questions

Appropriate professional boundaries are difficult to define and changeable in nature. The personality of the patient or client, the type of treatment, the status of the therapeutic association, and the character and clinical education of the therapist must all be considered during therapeutic interactions (Simon 1992, 1995). Many nurses are uncertain about what constitutes inappropriate or overinvolved behaviour in the workplace (Pennington et al., 1993; Smith et al., 1997). These nurses may have observed their colleagues exhibiting inappropriate, overinvolved behaviours, and may have committed various degrees of boundary crossings and violations themselves. In order for nurses to be able to identify boundary crossings and violations, a clear understanding of professional boundaries and the underlying principles involved is required. Consequently, boundary theory within the nurse-patient relationship, particularly personal and professional boundaries, boundary crossings, and boundary violations, continues to be of interest. To date, nurses have carried out limited research regarding boundary crossings and violations. The purpose of this research, therefore, is to explore the attitudes and behaviours of nurses working in the mental health field concerning professional boundaries, boundary crossings, and boundary violations within the nurse-patient relationship.

Definition of Terms

The following terminology is utilized throughout the research proposal:

1. *Personal boundaries* are considered to be "a dynamic line of demarcation separating an individual's internal and external environment, which varies in permeability and flexibility" (Scott, 1988, p. 24).

2. *Professional boundaries* have been defined as the "edge of appropriate behaviour" (Gutheil, 1994, p. 218), the "expected and accepted psychological and social distances between the physician and his or her patient" (Donen & Etkin, 1997, p. 13), "highly personal translations of moral codes in our relationships with others" (Curtis & Hodge, 1994, p. 21), and "limits that allow a patient and nurse to connect safely in a therapeutic relationship based on the patient's needs" (Smith et al., 1997, p. 28).

3. *Boundary crossings* are defined as "brief excursions across boundaries: with a return to the established limits of the professional relationship" (National Council of State Boards of Nursing, 1996, p. 11) and as the behaviour that "advances the therapy and neither harms nor exploits the patient" (Gutheil, 1994, P. 218).

4. *Boundary violations* are "the phenomena that occur when there is confusion of the professional's needs with the client's needs" (National Council of State Boards of Nursing, 1996, p. 11), behaviour that "harms the patient (usually by exploitation) and places the therapist's needs ahead of the patient's" (Gutheil, 1994, pp. 218-219), and "any behaviour that infringes upon the primary goal of

providing care, and that might harm the patient, the therapist, or the therapy itself" (Epstein, 1994, p. 2).

5. *Self-disclosure* was defined by Deering (1999) as "any revelation of personal ideas, biographical information or feelings" (p. 35).

6. *Dual relationships* are defined as "other kinds of relationships that coexist simultaneously with the physician-patient relationship" (Gabbard & Nadelson, 1995, p. 14), as "a professional-client interpersonal relationship that co-exists with the therapeutic or helping relationship" (Valentich & Gripton, 1992, p. 155), and as "relationships with a client of a nonsexual or nonerotic nature" (Jayaratne, Croxton & Mattison, 1997, p. 189).

7. *Sexual intimacy* in therapy was defined by Zelen (1985) as "any touching, fondling, kissing, or erotic acts including intercourse which occur between a patient and a therapist" (p. 178). Supportive, friendly, and nonerotic greetings, hugging, or kissing are not considered sexual intimacies.

8. *Sexual misconduct* is defined as "an extreme boundary violation that involves the use of power, influence, or knowledge inherent in one's profession to obtain sexual gratification, sexual partners, or sexually deviant outlets" (National Council of State Boards of Nursing, 1996, p. 11) and as the "expression of any thoughts, feelings, or gestures that may be construed by the patient as romantic or sexual in nature" (Wysoker, 2000, p. 131).

CHAPTER TWO

LITERATURE REVIEW

Introduction

In order to avoid inappropriate or overinvolved behaviour in the workplace, nurses require a clear understanding of the nature of the nurse-patient relationship and the related issues of power, transference, and countertransference. The nature and elements of current boundary theory to delineate personal and professional boundaries are reiterated. The meaning of crossing the line is explored, and the concepts of personal and professional boundaries, boundary crossings, and boundary violations within the nurse-patient relationship are reviewed. The North American demographic studies on the prevalence rates of sexual misconduct by physicians, psychologists, and nurses are summarized, and the effects of therapist-patient sexual intimacy are outlined.

Nurse-Patient Relationship

A clear understanding of the nurse-patient relationship is required by nurses in order to maintain professional boundaries and to identify inappropriate boundary crossings and violations. Every patient or client develops a relationship with the mental health professional who is caring for him or her (Gallop, 1998; Norman, 2000). Gordy (1978) stated that the nurse and the patient go through three stages in a therapeutic relationship, regardless of the relationship's length. These stages include (a) initiation, (b) working, and (c) termination. The interpersonal process of the nurse-patient relationship guides the patient toward increasingly independent interactions with the social environment (Peplau, 1952).

This interpersonal process is operationally defined in terms of four distinct phases (Carey, Noll, Rasmussen, Searcy, & Stark, 1989; Reed, 1996) which include (a) orientation, in which the patient becomes aware of the nurse's availability and trusts the nurse's competence; (b) identification, in which the patient identifies with the nurse, who allows the patient to express feelings and responds in a nonjudgmental manner; (c) exploitation, in which the patient works on identified goals in this major working phase of the relationship; and (d) resolution, in which the patient works through goals and gradually frees his or herself from identification with the nurse.

Morse (1991a) believed that current knowledge about the development and types of nurse-patient relationships is inadequate and that the patient-nurse relationship that is developed through trust, commitment, and involvement in relation to therapeutic goals has not been thoroughly investigated (Morse, 1991b). To that end, Morse (1991a) described a model for understanding the relationships that are mutually negotiated between the nurse and the patient. She found that, depending on (a) the length of the contact between the nurse and the patient, (b) the needs of the patient, (c) the patient's willingness to trust the nurse, and (d) the commitment of the nurse, one of four types of *mutual relationships* will appear. These mutual relationships include (a) a clinical relationship, (b) a therapeutic relationship, (c) a connected relationship, or (d) an overinvolved relationship. A *unilateral relationship* will develop if the nurse is reluctant or incapable of being committed to the patient and the patient persists in utilizing manipulative or demanding behaviours in an endeavour to expand the nurse's involvement in the relationship. Withdrawn or difficult behaviours are demonstrated by the patient if he or she is unwilling to trust the nurse and unable to accept his or her illness situation.

Professional behaviour can be described as existing on a continuum (Collins, 1989; National Council of State Boards of Nursing, 1995; Smith et al., 1997). At one end of the continuum is the underinvolvement indicated by cold and distant behaviour. The opposite end of the continuum signifies behaviour that is overinvolved and includes boundary violations such as dual relationships and sexual misconduct. The *zone of helpfulness* in the middle is the goal for nursing interactions. The nurse is an active agent in the treatment process, and the nurse-patient relationship is an important factor in positively influencing the patient's response to treatment (Collins, 1989). In *therapeutic use of self*, defined as "the use-of-self in the nurse-client relationship for therapeutic purposes" (Canadian Federation of Mental Health Nurses, 1995, p. 12), the nurse functions as both a therapeutic tool and a participant in the therapeutic process.

Power, Transference, and Countertransference

Power is defined as the "ability to influence another to behave in accord with one's wishes' (Gillies, 1989, p. 147) and the ability "to bring about a change in the behaviour or attitudes of other individuals" (Stoner, 1982, p. 304). Power grows out of interactions between individuals (Gillies), and Smith et al. (1997) asserted that the very nature of the nurse-patient relationship leads to personal rather than professional relationships. Nurses are expected to provide intimate personal care to patients (Gallop, 1993; Morse, 1989) and to manage the patient's suicidal, aggressive, or psychotic behaviour (Gallop, 1993). Nurses are also privy to private and confidential information about the patient. These factors lead to a power imbalance, with the nurse in the position of power (Bachmann, Moggi, Stirnemann-Lewis, Sommer, & Brenner, 2000; Backlar, 1996; Gallop, 1993, 1998; Morse, 1989; Norman 2000; Smith et al., 1997), and to unavoidable transference and countertransference issues. Within the nurse-patient relationship, *transference* refers to "the emotional reaction the nurse evokes in the patient based on previous relationships" (Smith et al, 1997, p. 28) and to "the patient reacting emotionally to the nurse as though she/he were an important person in his or her life (e.g., mother, father, wife, boyfriend, etc.)" (Gallop, 1993, p. 30). The emotions experienced often originate from childhood relationships within the family. These feelings are unconsciously projected onto the present significant person as if that person were the original recipient of those feelings (Schroder, 1985). The patient is not usually consciously aware of the connection between his or her response to the nurse and the person the nurse represents.

Countertransference is defined as the "emotional reaction the patient evokes in the nurse based on previous relationships" (Smith et al, 1997, p. 28) and as the nurse's emotional response to the patient "as though he/she were an important figure in his or her life" (Gallop, 1993, p. 30). Countertransference reactions can either facilitate or interfere with the development of a nurse-patient relationship (Schroder, 1985). Boundaries are more likely to erode if the nurse is not continuously vigilant regarding countertransference feelings. For example, if the nurse experiences an inappropriate attraction to a patient, the nurse may recognize that it is a normal response. However, the nurse must recognize the response as nontherapeutic and must be vigilant against using the patient to fulfill unmet needs.

Boundary Theory

Personal Boundaries

1 Scott (1988) defined a personal boundary as "a dynamic line of demarcation separating an individual's internal and external environment, which varies in permeability and flexibility" (p. 24). *Personal boundaries* have been conceptualized as four attributes or spheres (Lerner, 1988; Whitfield, 1993) and include (a) physical boundaries, (b) emotional boundaries, (c) intellectual boundaries, and (d) spiritual boundaries. *Physical boundaries* are comfort zones and involve the need for personal space. A person with impaired physical boundaries may have experienced mistreatment in the form of physical or sexual abuse and may spend an inordinate amount of time alone or with others (Hoover, 1995). *Emotional boundaries* are formed in early life and allow differentiation of the emotions that belong to the individual and those that belong to others, and 2 they protect the self from the emotions of others (Lerner). Emotional boundary impairment may result from verbal abuse and the lack of ability to verbalize feelings. This person may focus on pleasing others, rather than pleasing him or herself (Hoover). *Intellectual boundaries* enable a person to evaluate information from the outside before accepting it as one's own (Lerner). Individuals with impaired intellectual boundaries may experience difficulty in seeing themselves as separate individuals and often fear conflict, leading to acquiescence with

others' opinions. These fears may lead to an inability to express personal beliefs and to make personal decisions (Hoover). *Spiritual boundaries* enable a feeling of connection to and acceptance by a higher power, even if mistakes are made (Lerner). Spiritual boundary impairment results in the individual viewing his or her God as a harsh judge, with a resulting expectation of perfection of self. This person may easily incorporate others' spiritual advice or express a lack of purpose or meaning in life (Hoover). *Impaired personal boundaries*, accordingly, were defined by Hoover as "(a) the lack of awareness of self as separate from others physically, intellectually, emotionally, or spiritually; and (b) the inability to set limits within the four spheres during human interactions" (p. 11).

Personal space boundaries, as outlined by Scott (1993), form dynamic lines of differentiation between an individual's internal (mind, body, and spirit) and external environments. These personal space boundaries can be defined as a "series of paired dynamic, invisible lines of demarcation that differentiates four concentric areas of personal space." These four areas are described as "(a) the inner spirit core, (b) thoughts and feelings perceived as unacceptable, (c) thoughts and feelings perceived as acceptable, and (d) sphere of superficial public image" (Scott & Dumas, 1995, p. 14).

Boundaries are thought to vary in both permeability and flexibility. *Permeability* is defined as "the degree of openness or closedness of a personal space boundary, ranging from maximally open to maximally closed" (Scott & Dumas, 1995, p. 15). The individual's degree of availability to the external environment is determined by the permeability of the boundary, which allows physical, mental, and spiritual stimuli to enter or leave the internal space. *Flexibility* is defined as "the repertoire of behaviours that exist within an individual along the permeability continuum of opened to closed" (p. 15). The individual with flexible boundaries is able to choose a behavioural response that is situationally specific and culturally appropriate. Individuals who are aware of their boundaries and who are able to consciously regulate them seem to have healthier bodies, behaviours, and relationships. *Boundary regulation* is defined as an "interactive biopsychosocial process in which people make themselves more or less available to the external environment" (p. 15).

In a study of 40 geriatric outpatients living independently in retirement residences, Louis (1981) found that the personal space needs of the elderly were different from those observed for younger subjects. In previous studies with children and young adults, it was found that both male and female clients approached an individual more closely than they allowed themselves to be approached. Louis found that elderly subjects in general allowed a nurse to approach them significantly closer than they would approach the same individual. Louis made three recommendations for nurses working with elderly clients. First, the nurse should approach the client slowly enough that the client can respond to let the nurse know that he or she feels uncomfortable. Secondly, the nurse should obtain at least implied consent that the client is willing to allow closer contact. Finally, the nurse should observe for indications that the client's personal space boundaries have been violated. The older client may allow the nurse to approach closer than is comfortable for them. "Clues or signs that indicate that the nurse has moved too close to the individual include the client's inching slowly away; responding sharply, with anger, or silence; refusing a procedure; or just appearing uneasy" (p. 400).

Awareness and application of personal boundary theory heightens the nurse's boundary awareness and allows the nurse to show respect for the integrity of the person. Nurses need to be able to identify their own personal space needs and to be able to modify their own needs to meet the needs of their clients (Louis, 1981). Observation and assessment of the patient or client's personal space boundaries can assist the nurse to establish better rapport and provide improved patient care to patients of all ages.

Professional Boundaries

Professional boundaries have been defined as the "edge of appropriate behaviour" (Gutheil, 1994, p. 218), the "expected and accepted psychological and social distances between the physician and his or her patient" (Donen & Etkin, 1997, p. 13), the "highly personal translations of moral codes in our relationships with others" (Curtis & Hodge, 1994, p. 21), and the "limits that allow a patient and nurse to connect safely in a therapeutic relationship based on the patient's needs" (Smith et al., 1997, p. 28). Appropriate professional boundaries are difficult to define. Variables such as the care setting, client needs and personality, the type of treatment or therapy, the status of the therapeutic alliance, and the character and training of the therapist must be considered (Simon 1992, 1995). The needs of the patient or client must take priority over the needs of the professional, and the guiding ethical principle is that of doing no harm (Frick, 1994). The maintenance of treatment boundaries is clearly the responsibility of the professional (Briant & Freshwater, 1998; Epstein, 1994; Gallop, 1993, 1998; Simon, 1992; Smith et al., 1997), and the standards of the relevant professional association or certifying body must be understood and adhered to.

Simon (1992, 1995) identified five principles regarding the establishment of boundaries, which include: (a) the *rule of abstinence*, in which the professional must refrain from obtaining personal gratification at the expense of the client; (b) the *duty to neutrality*, in which the professional should not interfere in the personal lives of patients; (c) the maintenance of the client's *autonomy and self-determination*; (d) the *fiduciary relationship*, in which the professional is required to act in the best interests of the client; and (e) *respect for human dignity*, which is the underling principle of all boundary guidelines. Simon (1992) has also identified boundary guidelines for psychotherapy. The guidelines are (a) preservation of the neutrality of the therapist, (b) support of the psychological separateness of the client, (c) safeguarding of the client's confidentiality, (d) informed consent for procedures and treatments, (e) verbal interaction with patients, (f) avoidance of personal relationships with the client, (g) limited physical contact, (h) decreased use of personal disclosure by the therapist, (I) establishment of a stable fee policy, (j) consistent, private, and professional treatment setting, and (k) specified, consistent session time and length.

It is essential that the nurse have a clear understanding of the nurse-patient relationship and the significance of transference and countertransference reactions. The nurse must recognize that sexual attraction to a patient is a result of a transference-countertransference reaction and must deal with that attraction appropriately (Bachmann et al., 2000). The nurse must then identify and recognize his or her own personal and professional boundaries. Finally, the nurse must be able to recognize and understand the range of behaviours that constitute boundary crossings and boundary violations.

Boundary Crossings

Boundary crossings are defined as "brief excursions across boundaries: with a return to the established limits of the professional relationship" (National Council of State Boards of Nursing, 1996, p. 11) and as the behaviour that "advances the therapy and neither harms nor exploits the patient" (Gutheil, 1994, p. 218). Boundary crossings are "gray zones" (Alberta Association of Registered Nurses, 1998; Frick, 1994) which include *gift giving* and *personal disclosure*.

Gift Giving

When a nurse has privileged information about the patient and provides intimate personal care through physical contact, an inherent power imbalance occurs in the nurse-patient relationship, with the nurse holding the power (Gallop, 1993; Morse, 1989; Smith et al., 1997). This power imbalance creates dependency and passivity in the patient and a feeling of obligation to reciprocate for the care given by the nurse. Patients attempt to correct the imbalance of this obligation, usually at the termination of the nurse-patient relationship, with a personal gift to their nurse or a gift to the staff as a whole. Morse determined the structure and components of gift giving in a hospital setting. She verified that gift giving in hospital is consistent with gift giving norms outside of the hospital. Morse described the characteristics, timing, distribution, receiving, and refusal of gifts given to nurses by patients and family members. Patients may use gifts in an attempt to balance the power disparity and sense of obligation, or to manipulate the nurse into increasing personal attention, or as a payment for service.

In a study of 44 nurses, Morse (1991b) determined that gift giving by patients was perceived by the nurses as fitting into one of five categories. These categories of gifts from patients included (a) gifts to reciprocate for the care given, (b) "gifts intended to manipulate or to change the quality of care yet to be given, or to change the relationship between the nurse and the patient" (p. 602), (c) gifts given because of a perceived obligation, (d) "serendipitous gifts or perks and rewards received because of the nature of nursing or by chance" (p. 602), and (e) gifts given to the organization as a tribute to the superb nursing care received. Morse stated that nurses should accept gifts of gratitude and obligation, whereas manipulative gifts should be refused. More nursing research is needed in this area.

Personal Disclosure

The philosophical shift in nursing from a biomedical model to a more holistic one has led to the current trend of increased self-disclosure by nurses in therapeutic situations (Deering, 1999; Young 1988). Self-disclosure is defined by Deering as "any revelation of personal ideas, biographical information or feeling" (p. 35) and by Curtis (1981) as "the therapist's act of imparting personal or private information, including, but not limited to, feelings, beliefs, attitudes, values, experiences and the like, during a therapeutic interaction" (p. 499). Ashmore and Banks (2001) stated that self-disclosure is "a process by which we let ourselves be known to others" (p. 48) and that it is one of the integral skills in the diverse range of therapeutic approaches employed in mental health nursing. Nurses and other health professionals have been socialized to uphold a professional distance and have been educated not to disclose personal information about themselves to their patients. However, it is now believed that clinical self-disclosure can be therapeutic in the clinical environment if utilized appropriately.

Within the framework of the therapeutic helping relationship (genuineness, empathy, and unconditional positive regard), Young (1988) hypothesized that clinical self-disclosure (a) encourages genuineness, (b) decreases the social distance between the professional and the nurse, (c) promotes empathic understanding, and (d) facilitates patient self-disclosure. Van Servellen (1997) stated that self-disclosure has four main therapeutic effects for the patient (a) a sense of being understood, (b) the enhancement of trust, (c) the reduction of loneliness, and (d) the lessening of role distancing. Four goals of therapeutic self-disclosure by nurses have been identified by Deering (1999) (a) educating patients by using self as an example, (b) normalizing patient's experiences by sharing own reactions and experiences, (c) facilitating a patient's emotional catharsis to allow disclosure of emotions, and (d) conveying support by revealing positive feelings towards the patient. Deering has developed seven guidelines to consider when using therapeutic self-disclosure: (a) The professional should use self-disclosure only to help the patient open up, not to meet the professional's own needs; (b) self-disclosure should be brief; (c) the professional should not imply that his or her own experience is exactly the same as the patient's; (d) self-disclose should be used only to describe situations that the professional has handled successfully; (e) the professional's comfort level with self-disclosure should be monitored; (f) cultural variations in the amount and type of self-disclosure deemed appropriate should be considered; and (g) the patient's need for privacy should be respected. Personal self-disclosure has the effect of operationalizing the therapeutic relationship and facilitating patient self-disclosure.

Boundary Violations

Boundary violations are "the phenomena that occur when there is confusion of the professional's needs with the client's needs" (National Council of State Boards of Nursing, 1996, p. 11), behaviour that "harms the patient (usually by exploitation) and places the therapist's needs ahead of the patient's" (Gutheil, 1994, pp. 218-219), and "any behaviour that infringes upon the primary goal of providing care, and that might harm the patient, the therapist, or the therapy itself" (Epstein, 1994, p. 2). Typically, four components are present when nursing professionals commit boundary violations (Linklater & MacDougall, 1993; Panelli, 1996; Peterson, 1992): (a) role reversal, in which the nurse looks to the patient to get personal needs met; (b) secrecy, in which the nurse selectively shares information or keeps information from the patient or the treatment team;

(c) double bind, in which the nurse communicates two sets of messages that contradict each other, with the patient fearing abandonment if an attempt is made to set limits; and (d) indulgence of professional privileges, in which the nurse uses information obtained from the patient for personal profit.

Brown (1994) believed that boundary violations have three characteristics that include: (a) *objectification of the patient*, in which the patient is viewed as a resource for the therapist's educational, entertainment, or sexual needs; (b) *impulsivity of actions*, in which consideration is not given to the meaning of the therapist's actions; and (c) *the needs of the more powerful therapist take precedence*, and a power imbalance occurs in an already power-imbalanced relationship. Sommers-Flanagan, Elliot, and Sommers-Flanagan (1998) believed that not all boundary violations are negative. Taking into account the three aspects of a boundary violation as described by Brown above, the therapist considering violating a boundary should (a) discuss the reasons for the proposed boundary violation with the client, (b) outline the potential liabilities, and (c) ensure that the client feels able to agree or not to agree to the boundary violation.

Crossing the line refers to the action of moving past a specific border into a boundary violation (Cameron, 1997; Panelli, 1996; Peterson, 1992). It has recently been argued in the nursing literature that it may be more useful to regard boundary violations as a "slippery slope" or a process with a succession of steps rather than a line that cannot be crossed (Cameron; Panelli; Peterson). The nurse should reevaluate his or her interactions with the patient at each step to ensure maintenance of professional boundaries. Boundary violations include *dual relationships* and *sexual misconduct*.

Dual Relationships

Dual relationships, also known as *double agency* (Simon, 1992), is a term that is not widely used in the nursing profession, and the current information has been obtained from the social work and psychology literature. Dual relationships are defined as "other kinds of relationships that coexist simultaneously with the physician-patient relationship" (Gabbard & Nadelson, 1995, p. 14) as "a professional-client interpersonal relationship that coexists with the therapeutic or helping relationship" (Valentich & Gripton, 1992, p. 155), and as a "relationship with a client of a nonsexual or nonerotic nature" (Jayaratne et al., 1997, p. 189). Nonsexual dual relationships "occur when the therapist is in another, significantly different relationship with one of his or her patients" (Pope, 1991, p. 21). Dual relationships (Bader, 1994; Pope; Valentich & Gripton) can be (a) social, such as personal relationships and friendships; (b) financial, such as transactions involving money or bartering; (c) professional, such as entering into a role of teacher, spiritual advisor, or counsellor with a relative or friend; or (d) business: engaging in ventures together. A professional enters into a dual relationship whenever a second role is assumed with the patient (Kagle & Giebelhausen, 1994).

In any dual relationship the professional's influence and the patient's vulnerability carry over to the second relationship blurring the roles of practitioner and client, leading to a conflict of interest and permitting the abuse of the professional's power (Bader, 1994; Kagle & Giebelhausen, 1994). The National Association of Social Workers (NASW) in 1993 confirmed that "the social worker should not condone or engage in any dual relationships with clients or former clients in which there is a risk of exploitation of or potential harm to the client" (p. 5). The American Psychological Association (APA, 1992) recognized that "in many communities and situations it may not be feasible or reasonable for a psychologist to avoid social or other non-professional contacts" (p. 1601). The APA also cautioned against entering into a dual relationship if "it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist effectively performing his or her functions as a psychologist or might harm or exploit the other party" (p. 1601). Therefore, the APA code acknowledged the complexity of context in dual relationships and clarified that the prohibition applies to a wide range of professional roles (Brownlee, 1996).

In a study of more than 2,300 psychiatrists, psychologists, and social workers, Borys and Pope (1989) examined the attitudes and practices regarding dual professional roles, social involvements, financial involvements, and incidental involvements. More than 90% of the respondents reported that they had never engaged in any of the behaviours other than receiving a small gift from a patient or providing individual therapy to a relative, friend, or partner of an ongoing patient. The three professions did not differ among themselves in terms of (a) a nonsexual dual professional role, (b) social involvements, or (c) financial involvements with patients. Borys and Pope concluded that dual relationships are both exploitive and clinically harmful in nature and outlined 10 specific implications regarding training.

Jayaratne et al. (1997) studied the beliefs and behaviour of 846 professional social workers (response rate 56.6%) from the Michigan chapter of the National Association of Social Workers (NASW) regarding: (a) *intimate relationships*, erotic or sexual contact; (b) *dual relationships*, entering into a second relationship that runs concurrently with the therapeutic relationship; (c) *mixed modalities*, using nontraditional treatment with standard social work techniques (prayer, astrology, yoga, tai chi chuan, and therapeutic touch); (d) *advice giving*, contributing advice on subjects of a nontherapeutic nature; (e) *boundary behaviours*, transactions outside traditional behavioural limits; and (f) *financial transactions*, behaviours associated with payment of professional services (fees, third-party payments, bartering). Mixing modalities appeared common with dual relationships, and financial transactions seem to be the most problematic. The authors concluded that more specific practice guidelines for social workers are required.

Sexual Misconduct

Zelen (1985) defined *sexual intimacy* in therapy as "any touching, fondling, kissing, or erotic acts including intercourse which occur between a patient and a therapist" (p. 178). Supportive, friendly, and nonerotic greetings, hugging, or kissing are not considered sexual intimacies. Sexual misconduct takes place when the health care provider initiates sexual intimacy with a patient or responds to a patient in a sexual way (Smith et al., 1997) and is defined as "explicit sexual relations between therapist and patient" (Gutheil, 1994, p. 218) and as "an extreme boundary violation that involves the use of power, influence, or knowledge inherent in one's profession to obtain sexual gratification, sexual partners, or sexually deviant outlets" (National Council of State Boards of Nursing, 1996, p. 11).

In the therapist-patient situation an unequal distribution of power occurs, with the therapist in the dominant role (Backlar, 1996; Blackshaw & Patterson, 1992; Briant & Freshwater; 1998; Brown, 1988; Butler & Zelen, 1977; Gallop, 1993, 1998; Holroyd & Brodsky, 1977; Taylor & Wagner, 1976; Zelen, 1985). The therapist is in a higher status position due to his or her role as a professional and because of the personal knowledge that the therapist has about the client (Gallop, 1993, 1998; Strasburger et al., 1992; Taylor & Wagner, 1976). Furthermore, the clear majority of the incidents of therapist-patient sexual contact occur between male therapists and female patients (Apfel & Simon, 1985; Blackshaw & Patterson; Gallop, 1998; Gartrell, Herman, Olarte, Feldstein, & Localio, 1986; Holroyd & Brodsky), for the reason that in our culture sexual relationships are more likely to develop between a more powerful male and a less powerful female (Blackshaw & Patterson). Women are also conditioned culturally to be attractive (Blackshaw & Patterson), compliant (Blackshaw & Patterson; Marmor, 1972), and "willing to let others' needs supersede her own" (Blackshaw & Patterson, p. 352). The therapist is now held to the standard of fiduciary for the patient, requiring that the therapist act in the patient's best interests (Appelbaum & Jorgenson, 1991; Strasburger et al., 1992).

Sexual attraction to a patient is a common and normal experience of health care practitioners (Bachmann et al., 2000; Briant, 1997; Folman, 1991; Gabbard, 1996; Kluft, 1989; Patterson & Blackshaw, 1993; Pope, 1987, 1988; Pope, Keith-Spiegel, & Tabachnick, 1986; Schafer, 1997) but most feel guilty, anxious, or confused about the attraction (Briant; Pope et al.). All practitioners should seek support and consultation or supervision to deal with these feelings and to assist with boundary maintenance (Barakat & De Cloedt, 1997; Briant; Folman; Gallop, 1993). Most mental health professionals have received little education in their training programs to help prevent them from acting on these feelings (Folman; Patterson & Blackshaw; Gabbard & Nadelson, 1995), and the nursing profession is particularly deficient in addressing this issue (Schafer).

Increased education about the dynamics of transference and countertransference (Blackshaw & Paterson; Collins, 1989; Folman; Gabbard, 1995, 1996; Gutheil & Gabbard, 1998; Marmor, 1970, 1972; Strasburger et al., 1992) and the context of therapist-patient sexual contact is essential to the prevention of boundary violations (Gabbard, 1996; Gabbard & Menninger, 1991; Gabbard & Nadelson; Gutheil & Gabbard, 1993, 1998; Zelen, 1985). Courses in professional ethics with a focus on the development of ethical decision making and judgement (Berliner, 1989; Blackshaw & Paterson; Pope & Bajt, 1988) and gender-role behaviour and gender-related issues (Blackshaw & Paterson) are also required. Malpractice complaints to licensing boards, ethics committees, and the civil courts indicate that therapist-patient sexual intimacy is a major problem for health care professionals (Goisman & Gutheil, 1992; Schoener, 1995; Simon, 1988; Strasburger et al., 1992).

As stated earlier, the sexual involvement of a professional with a patient tends to follow a predictable course, with minor boundary crossings gradually progressing on a continuum to major boundary violations (Simon, 1995; Sommers-Flanagan et al., 1998). This phenomenon is described as the *slippery slope* of boundary violations (Brown, 1988; Donen & Etkin, 1997; Gabbard, 1996; Gabbard & Nadelson, 1995; Gutheil & Gabbard, 1998; Strasburger et al., 1992) and identifies the thoughts, feelings, and actions that may lead health care professionals to violate professional boundaries. Gutheil and Simon (1995) suggest that early boundary violations in psychotherapy often first appear in the transition zone between the chair and the door.

The Exploitation Index (EI) is a self-assessment questionnaire for therapists that may be utilized as an early-warning indicator of therapist boundary violations (Epstein & Simon, 1990). The usefulness of the Exploitation Index was evaluated in a survey of 6,000 psychiatrists and medical psychoanalysts in the United States (Epstein et al., 1992). A moderately high coherence within the item set was indicated by a Cronbach's Alpha of 0.81 for the 32-question EI. Of the 532 psychiatrists that participated in the study, 43% found that one or more questions in the Exploitation Index alerted them to boundary violations. An additional 29% stated that the questionnaire stimulated them to make specific changes in future treatment practices (Epstein et al.). Pilette, Berck, and Achber (1995) designed the Nursing Boundary Index, a modification of the Exploitation

Index to facilitate education and self-assessment of psychiatric nurses working in inpatient settings.

Effects of Sexual Intimacy

Sexual abuse or sexual impropriety has long-term harmful effects for the patient (Gutheil, 1989; Kluft, 1989) and damages the patient's self-esteem and ability to trust others (Gallop, 1993; Pope et al., 1986). The disadvantages to the patient appear to far outweigh the positive effects (Apfel & Simon, 1985; Collins, 1989). Apfel and Simon identified a number of negative effects of therapist-patient sexual contact, which include the patient's (a) ambivalence and mistrust of subsequent therapists, (b) doubting of own sense of reality, (c) childhood trauma repeated and habituated, (d) intensification of the original complaints of sexual dysfunction and problems in intimacy, (e) increased guilt and shame, (f) subjugation to the therapist, (g) inability to use imagination to envision and explore alternatives (particularly in regards to sexuality), and (h) disorganization when stranded by the abrupt ending of a relationship.

Pope and Bouhoutsos (1986) have determined that the emotional consequences of sexual intimacy for the patient include (a) exacerbation of preexisting psychiatric disorders, (b) production of the therapist-patient sex syndrome, (c) damage to personal relationships, and (d) destructiveness to future treatment. The 10 aspects commonly associated with the therapist-patient sex syndrome (Pope, 1988) include

> (a) ambivalence; (b) a sense of guilt; (c) feelings of emptiness and isolation; (d) sexual confusion; (e) impaired ability to trust; (f) identity, boundary, and role confusion; (g) emotional lability (frequently involving severe depression and acute anxiety); (h) suppressed rage; (i) increased

> suicidal risk; and (j) cognitive dysfunction (especially in the areas of attention and concentration, frequently involving flashbacks, nightmares, intrusive thoughts, and unbidden images). (p. 222)

Educator-Student Boundary Violations and Sexual Intimacy

Most professional mental health education programs spend relatively little time addressing issues of sexual attraction to or sexual contact with patients or clients (Gartrell, Herman, Olarte, Localio, & Feldstein, 1988; Gartrell, Milliken, Goodson, Thiemann, & Lo, 1992; Glaser & Thorpe, 1986; Pope, 1988; Pope & Bouhoutsos, 1986; Pope et al., 1986). Medical educators are becoming increasingly aware of the need for increased training in this area. One such program has been developed at the University of Toronto and includes: (a) a didactic component, consisting of lectures on the definitions, causes, and consequences of physician-patient sexual misconduct and teacher-learner mistreatment and harassment; and (b) an experiential component, consisting of a workshop utilizing vignettes (Robinson & Stewart, 1996a, 1996b).

As well, educator-student boundary violations and sexual intimacy have been studied (Carr, Robinson, Stewart, & Kussin, 1991; Gartrell et al., 1988; Glaser & Thorpe, 1986; Komaromy, Bindman, Halver, & Sande, 1993; Margittai & Moscarello, 1994; Pope, Levenson, & Schover, 1979; Robinson & Reid, 1985), and it is apparent that the sexualization of this relationship has a tendency to hinder open and honest discussion of sexual feelings that are a normal part of many therapies (Gordon, Labby, & Levinson, 1992; Pope, 1988, 1989). It is always the responsibility of the educator to define and maintain professional boundaries within the educator-student relationship (Barakat & De Cloedt, 1997).

Truly consensual sexual relationships between the teacher and the learner are unlikely due to the unequal power balance inherent in such relationships (Gordon et al.; Robinson & Stewart, 1996a). The teacher can control the student's career through grades, evaluations, and recommendations. Sexualization of the educator-student relationship has consequences for the student, the educator, and the subsequent relationships that each will experience. The extent to which sexual intimacy in the educator-student relationship may have negative effects on the teaching and learning of professional skills remains unknown (Gartrell et al.; Pope, 1989; Pope, Schover, & Levenson, 1980), but students' "feelings of guilt, shame and self doubt are common, as are mistrust of faculty and disillusionment with the profession" (Gordon et al., p. 445). Research has suggested that due to a modeling effect, students who become sexually involved with teachers or supervisors are more likely to have sexual contact, as therapists, with clients (Carr et al.; Gartrell, et al.; Gordon et al.; Pope, 1989; Pope et al., 1979; Strasburger et al., 1992). See Table A2 in Appendix A.

Demographic Studies

In a nationwide American study, Pope, Levenson, and Schover (1979) randomly sampled 500 male and 500 female psychologists from the American Psychological Association (APA) Division 29 (Psychotherapy). Respondents were asked (a) if they had engaged in sexual contact as students with their educators, (b) if they had engaged in sexual contact as educators with their students, and (c) if they had engaged in sexual contact as therapists with their patients. Of the 481 respondents (48% response rate), 10% (3% of the men and

16.5% of the women) reported sexual contact as students with their educators (psychology teacher, clinical supervisor, or administrator). Sexual contact as educators with students was reported by 13% (8% of the women and 19% of the men). Sexual contact with clients was reported by 7% of the respondents (3% of the women and 12% of the men) following graduation. Of those respondents who had sexual contact with students or clients, 43% believed that such relationships were definitely not helpful to both parties.

In a survey of 954 female doctorates in psychology from the 1978 APA membership directory, 287 psychologists (response rate 30%) reported attitudes and experiences regarding sexual harassment and sexual contact (Robinson & Reid, 1985). As students, almost half (48.1%) of the respondents experienced sexual advances/harassment with psychology educators (teachers, administrators, and training supervisors), and 13.6% reported sexual contact. As employees, 32.8% experienced sexual advances/harassment, and 7% reported sexual contact in the workplace. Most of the respondents (95.7%) felt that the sexual relationships were probably harmful to one or both parties. The authors recommended that training and orientation programs should educate students and employees to (a) minimize and alleviate inappropriate sexual desires, and (b) deal assertively with sexual advances.

Glaser and Thorpe (1986) surveyed all 1,047 female psychologists from the APA Division 12 (Clinical Psychology) residing in the United States and Canada. Of the 464 respondents who participated (44% response rate), 17% indicated that they had engaged in intimate sexual contact with one or more psychology educators (course instructor, research/academic advisor, clinical supervisor, or other psychology educator) during graduate training. A number of the participants (31%) reported that they had received sexual advances from psychology educators that had not led to actual sexual contact. When questioned about their attitudes relating to sexual contact between a graduate student and a psychology educator, such behaviour was considered (a) highly ethically inappropriate (79.5%), (b) very coercive or exploitive (51%), and (c) very harmful to the working relationship (66%). Only 12% of the participants received training that addressed the issue of educator-student sexual contact, and only 22% received comprehensive training regarding therapist-client sexual contact.

In a national United States survey of 1,113 PGY-4 psychiatric residents by Gartrell et al. (1988), 548 respondents (50.4% response rate) reported on the prevalence of educator-resident and resident-patient sexual contact. Of those who responded, 4.9% stated that they had been sexually involved with psychiatric educators, and 0.9% reported that they had been sexually involved with patients. Most reported no or minimal instruction in their residency programs about educator-resident and patient-resident sexual contact. The researchers identified a need for an expanded training curriculum to include specific education on sexual exploitation.

Carr et al. (1991), in a national survey of all 535 Canadian psychiatric residents, gathered information about the incidence of residents' sexual contact with educators and the education they had received about such relationships in postgraduate education programs. Of the 314 participants (response rate

58.7%), six (4.1%) of the female residents and two (1.2%) of the male residents reported sexual contact with educators. Sexual harassment by an educator was reported by 14 (9.7%) of the female residents, with no reports by male residents. The residents' education concerning resident-educator sexual contact was inadequate with only 8.6% stating that they had received thorough instruction. Most residents 81.2% believed that sexual contact with a patient was always unethical under any circumstances, but 17.8% felt that it was allowable if therapy had been completed. Only one resident acknowledged having sexual contact with a patient. The authors concluded that continuing education and clear departmental policies were required to ensure the protection of vulnerable residents during training.

Komaromy et al. (1993) surveyed 133 internal medicine residents at the University of California in San Francisco regarding sexual harassment. Of the 82 residents who responded (62% response rate), 43% (73% of the women and 22% of the men) reported sexual harassment at least once during their training. The women's harassers were more likely to be of higher professional status. The authors concluded that the sexual harassment experienced during medical training often creates a hostile learning environment and that educational institutions need to address the adverse effect that sexual harassment might have on medical education and patient care.

A study of 396 first and fourth-year medical students at the University of Toronto measured medical students' experiences of abuse during medical training (Margittai & Moscarello, 1994). Of the 347 respondents (88% response rate), 71% of the respondents reported abuse, which was defined as verbal, emotional, or physical abuse, and sexual harassment. The surgical rotation was the most common setting for abuse, with 66% of medical students not reporting the abuse for fear of retribution. The experience of abuse within the educator-student relationship was correlated with an increased incidence of later patient mistreatment (22% versus 2%).

Therapist-Patient Sexual Intimacy

A number of studies have addressed the attitudes towards and incidence of sexual misconduct by physicians (Gartrell et al., 1986; Gartrell et al., 1992; Herman, Gartrell, Olarte, Feldstein & Localio, 1987; Kardener et al., 1973; Perry, 1976) and psychologists (Akamatsu, 1988; Borys & Pope, 1989; Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983; Butler & Zelen, 1977; Feldman-Summers & Jones, 1984; Holroyd & Brodsky, 1977; Pope et al., 1986; Pope, Tabachnick, & Keith-Spiegel, 1987; Pope & Vetter, 1991; Stake & Oliver, 1991). However, few studies have addressed therapist-patient sexual contact in the hospital setting (Averill et al., 1989; Collins, 1989; Gallop, 1998; Stone, 1975) or in correctional institutions (Schafer, 1997). There has also been limited research regarding the attitudes toward and incidence of sexual misconduct by social workers (Bernsen, Tabachnick, & Pope, 1994; Gechtman, 1989, Gechtman & Bouhoutsos, 1985; Jayaratne et al., 1997), nurses (Bachmann et al., 2000; Munsat & Riordan, 1990; Nursing, 1974), occupational therapists, or rehabilitation therapists.

Demographic Studies

Formal demographic studies tend to focus on health care professionals who violate professional boundaries and have primarily described the attitudes and behaviours of therapists who report sexually intimacy with clients. Table A1 (adapted from Pope, 1988, 1993; Pope & Bouhoutsos, 1986), in Appendix A presents the prevalence studies that have been published over the past 20 years. The very different criteria for sample selection make it difficult to compare these data, but it is clear that male therapists engage in therapist-client sexual intimacy at higher rates than female therapists do.

Medicine

In a landmark Los Angeles survey, Kardener et al. (1973) randomly sampled 1,000 male physicians from the specialties of psychiatry, general practice, internal medicine, obstetrics/gynecology, and surgery. Of the 460 male respondents, 59% engaged in nonerotic contact with patients, 12.8% engaged in erotic behaviour (of any kind), and 7.2% engaged in erotic behaviour with intercourse. Erotic behaviour was defined as "behaviour, which is primarily intended to arouse or satisfy sexual desire" (p. 1077). Nonerotic behaviour was identified as "hugging, kissing and affectionate touching" (p. 1078). Of the 114 psychiatrists surveyed, 56% engaged in nonerotic behaviour with patients, 10% reported erotic behaviour (of any kind), and 5% reported erotic behaviour with intercourse. Kardener et al. concluded that "the freer a physician is with nonerotic contact, the more statistically likely he is to also engage in erotic practices with his patient" (p. 1325).

Perry (1976) surveyed 500 female physicians to determine if there were differences between male and female physician practice regarding physical contact with patients. The study was designed to parallel and expand on the research of Kardener et al. (1973). Of the 164 female physicians (from 17 different specialties) who responded (33% response rate), 79% reported engaging in nonerotic touching. Of the 30 psychiatrists who responded, 73% engaged in nonerotic touching. None of the physicians surveyed reported erotic contact with intercourse. One physician, a pediatrician, reported erotic contact without intercourse. Perry concluded that female physicians consistently oppose erotic involvement with patients, and although male physicians also oppose erotic involvement with patients, they are much more likely to actually engage in erotic contact.

A national United States survey of 5,574 psychiatrists (Gartrell et al., 1986; Herman et al., 1987) was conducted to assess psychiatrists' attitudes toward sexual contact with patients and to determine the prevalence of sexual misconduct. A total of 1,423 psychiatrists (26% response rate) participated, with 7.1% of the 1,057 male respondents and 3.1% of the 257 female respondents acknowledging sexual contact with patients. Sexual contact was defined as "contact, which was intended to arouse or satisfy sexual desire in the patient, therapist, or both" (p. 1127). As well, 88% of the sexual contact occurred between male psychiatrists and female patients. Consultation was sought by 41% of those psychiatrists sexually involved with patients.

Gartrell et al. (1992), in a national follow-up to their 1986 study, surveyed 10,000 American obstetrician-gynecologists, family practitioners, internists, and surgeons to document the prevalence of physician-patient sexual contact and to estimate its effect on involved patients. Of the 1,891 respondents (19% response rate), 176 (9%) acknowledged sexual contact with one or more patients. Of the respondents, 164 (10%) of the men and 12 (4%) of the women admitted to sexual contact with patients. Sexual contact with more than one patient was reported by 42% of the involved physicians, and the largest number of contacts reported by a physician was 11. Of those who responded, 23% had at least one patient who reported sexual contact with another physician, and 63% thought that sexual contact was always harmful to the patients. Almost all (94%) of the participants opposed sexual contact with current patients, and 37% also opposed contact with former patients. More than half (56%) reported that physician-patient sexual contact was never discussed in their training. Gartrell et al. concluded that clear and enforceable medical ethics codes pertaining to physician-patient sexual contact are required, as well as preventive education programs for medical schools and residency programs.

Psychology

In a notable nationwide American survey of 500 male and 500 female doctorally prepared psychologists with a 70% return rate, Holroyd and Brodsky (1977) found that 5.5% of the 347 male respondents and 0.6% of the 310 female respondents had engaged in sexual intercourse with patients. An additional 2.6% of the male and 0.3% of the female respondents reported sexual contact with patients within three months of termination of treatment. Sexual contact with more than one patient was acknowledged by 80% of the respondents reporting sexual contact with patients.

Bouhoutsos et al. (1983) surveyed all 4,385 licensed psychologists in California requesting responses about patients who reported incidents of sexual intimacy with a previous therapist. Sexual intimacy was not defined. Of the 704 psychologists that responded, 21 of the males (4.8%) and two of the females (0.8%) self-reported engaging in sexual intimacies with patients. Sexual intimacy between a previous psychotherapist and patient were reported by 318 psychologists who treated a total of 559 such patients. The vast majority (90%) of the patients were reported to have suffered ill effects (ranging from difficulties with trust to suicidal behaviour) from their sexual experience with a previous therapist.

Pope et al. (1986) surveyed 1,000 psychologists (500 men and 500 women) randomly selected from Division 42 (psychologists in private practice) of the APA. Of the 575 psychologists who responded (58.5% response rate), 87% reported feelings of sexual attraction to their clients (95% of the men and 76% of the women). As well, 9.4% of the men and 2.5 % of the women reported acting on their feelings of sexual attraction. A majority, 63%, felt guilty, anxious, or confused about the attraction. Approximately 50% stated that their training left them entirely without guidance, and only 9% reported adequate training or supervision. The researchers concluded that attraction to clients is a prevalent experience among both male and female psychologists.

A study of 1000 psychologists (500 men and 500 women) randomly selected from Division 29 (Psychotherapy) of the APA (Pope et al., 1987), surveyed psychologists about the degree to which they engaged in 83 behaviours and the degree to which they considered each behaviour to be ethical. Of the 456 psychologists (45.6% response rate) surveyed, only 1.9% reported engaging in sexual contact, and only 2.6% reported engaging in erotic activity. More than 95% of the respondents considered sexual contact and erotic activity with patients to be unethical.

Akamatsu (1988) randomly sampled 1,000 members of Division 29 (Psychotherapy) of the APA to determine attitudes and behaviour in regards to intimate relationships with former clients. Of the 395 respondents (39.5% response rate), 3.1% (3.5% of the male therapists and 2.3% of the female therapists) admitted to engaging in sexual contact with current patients. As well, 11% (14.2 of the male therapists and 4.7% of the female therapists) admitted to sexual contact with former clients. Intimate relationships with former patients were considered (a) highly unethical by 44.7%, (b) somewhat unethical by 23.9%, (c) neither ethical nor unethical by 22.9%, and (d) somewhat or highly ethical by 8.5%. The author concluded that the establishment of APA ethical guidelines was clearly indicated.

In a national survey of 1,320 psychologists randomly selected from the APA, Pope and Vetter (1991) asked the respondents to indicate how many of the patients whom they had treated reported sexual contact with a therapist prior to termination and how many, if any, suffered harm as a result. Of the 654 respondents (50% response rate), approximately half (323) reported treating at least one client who had been sexually intimate with a therapist. A total of 958 patients reported engaging in sexual contact with a previous therapist. Female patients were more likely to experience harm if the sexual contact was initiated before termination (95%) than after (80%).

Stake and Oliver (1991) surveyed all 1,041 licensed psychologists in Missouri concerning their (a) use of touch and sexually suggestive behaviours, (b) definition of sexual misconduct, (c) response to feelings of attraction to clients, and (d) reactions to client reports of previous therapist contact. Of the 320 respondents (31% response rate), 7.3% admitted to engaging in sexual contact with patients. A total of 43.6% of the respondents had treated clients who had reported sexual contact with a previous therapist. Stake and Oliver concluded that sexual misconduct remains a cause for serious professional concern and that greater attention to these ethical issues should be provided in the therapist's training.

Social Work

In a 1984 landmark national study, the attitudes and behaviours of 500 male and 500 female American social workers were studied regarding their attitudes and behaviours towards erotic contact with clients (Gechtman, 1989; Gechtman & Bouhoutsos, 1985). Erotic contact was defined as "one or more of the following activities: erotic kissing, erotic fondling or petting, oral-genital stimulation of or by clients, and sexual intercourse" (p. 29). Erotic contact either during or following therapy was reported by 3.8% of the male social workers. No female social workers reported erotic contact. Gechtman stated that the lower incidence of sexual contact between social worker and client may be due to: (a) the nature of a traditionally female profession, with men entering the profession possessing more of the tradition female traits of caring, responsibility, and sensitivity to the needs of others; (b) the tendency of social workers to practice in institutional or agency settings rather than private practice settings; and (c) less honesty in reporting sexual activities. The majority of the respondents (90%) believed that erotic contact between social worker and client was not beneficial under any circumstances. It is interesting to note that this study was first presented at the 1985 annual conference of the National Federation of Societies for Clinical Social Work but was later rejected for publication in a leading social work journal. The author concluded that the social work discipline is "tardy in recognizing and addressing sexual contact between its members and their clients" (p. 30) and that nonerotic contact with clients also requires further discussion and clarification.

In a national survey of 1,000 clinical social workers, Bernsen, Tabachnick, and Pope (1994) adapted the survey of psychologists developed by Pope et al. (1986). Of the 453 respondents (45% response rate) 50.6% were men and 49.4% were women. Ninety-two percent of the male social workers and 70.2% of the female social workers reported sexual attraction to a client. However, only 3.6% of the male social workers and 0.5% of the female social workers reported actually engaging in sex with a client. Fifty-one percent of the respondents reported that they had received no education or training about attraction to clients, and only 10% reported that they had received adequate education in this area.

Jayaratne et al. (1997) studied the beliefs and behaviour of 1,494 professional social workers from the Michigan chapter of the National Association of Social Workers (NASW) regarding (a) intimate relationships, (b) dual relationships, (c) mixed modalities, (d) advice giving, (e) boundary behaviours, and (f) financial transactions. Of the 846 respondents (response rate 56.6%), only 1.1% acknowledged having sex with a former client. Questions were not asked about sexual contact with current clients. Just over half of the respondents (52.4%) reported sexual attraction to a client, with 43.7% stating that such feelings are appropriate. The authors concluded that social workers require more specific practice guidelines to direct behaviour, clarification to resolve ambiguity and confusion, and education and feedback on practice behaviours.

Nursing

Sexual relationships between psychiatric mental health nurses and their patients or clients have not been well investigated. The actual incidence of sexual misconduct within the nursing profession is not known because there are no universal reporting requirements (Smith et al., 1997). In a self-report survey included in a national American nursing journal, results were obtained from over 11,000 nurses regarding ethical and interpersonal problems in nursing. In this survey, 2% of the male respondents and 0.3% of female respondents admitted to responding to sexual advances from a patient resulting in sexual intercourse

(Nursing, 1974). The survey was not a representative sample of nurses in the United States and Canada.

In another attempt to determine the prevalence of staff-patient sexual interactions, a national nursing study was completed for American psychiatric institutions in 1988 and 1989 (Munsat & Riordan, 1990). The 10-item questionnaire was sent to the psychiatric nursing clinical co-ordinators or directors of the 552 organizations with psychiatric units. Of the 305 (57%) responding hospitals with psychiatric units, 169 reported a total of 629 suspected, alleged, or actual events. The actual reported suspicions were 139 (23%), allegations were 384 (43%), and verified occurrences were 106 (23%).

In the only known survey of psychiatric nurses employed in psychiatric hospitals, carried out by Bachmann et al. (2000), a 35-item questionnaire was mailed to all 714 nurses employed at two psychiatric hospitals in Switzerland. The questions in the self-report survey were organized around the areas of (a) gender of the participants, (b) attitudes toward sexual contact in nurse-patient relationships, (c) characteristics of sexual contact with their own patients (if any), (d) nurses' own history of childhood sexual abuse, (e) number of colleagues known to have had sexual contact with patients, and (f) the need to provide help for nurses who have had sexual contact with patients. The response rate was 39%, with 94% of the 279 respondents reporting that they considered sexual contact with patients to be inappropriate and 92% of the respondents reporting that sexual contact would have negative effects on patients in the long run. Sexual contact was defined as "physical contact between a patient and a nurse, in which sexual arousal occurred in the nurse" (p. 335). Seventeen percent of the male and 11% of the female psychiatric nurses reported that they had sexual contact with patients. However, none of the male nurses and only four (1.4%) of the female nurses reported that they had engaged in sexual intercourse. The participants reported that sexual contact occurred following discharge (20%), both during and following hospitalization (23%), and while the patient was in hospital but was terminated on discharge (57%).

Joint Studies

To date there has been only one national study involving more than one discipline. In a national study of dual relationships between therapists and clients, a total of 4,800 psychologists, psychiatrists, and social workers (800 male and 800 female clinicians from each group) were surveyed by Borys and Pope (1989). The 2,332 participants (49% response rate) reported on dual professional roles, social involvements, financial involvements, and incidental involvements. Unexpectedly, in this study only 0.9% of the men and 0.2 % of the women reported engaging in sexual intimacies with an ongoing client. This discrepancy may be a result of (a) an actual decline in the rate of sexual intimacy with clients, (b) a decline in reporting due to social desirability response bias, and (c) unclear wording of the survey questions. However, it is apparent that a higher proportion of male therapists engage in both sexual and nonsexual dual relationships and that the three professions did not differ among themselves in regards to sexual intimacies with clients before or after termination. A majority of the respondents (98.3%) rated sexual activity with a client before termination of therapy as never ethical, and 68.9% considered sexual activity with a client after termination of therapy as never ethical.

Conclusion

After reviewing the literature, it is apparent that the attitudes and behaviours of physicians and psychologists regarding sexual misconduct and sexual boundary violations have been thoroughly investigated. Research has clearly shown that therapist-patient sexual intimacy is harmful to the patient. More recent research on educator-student sexual contact illustrates the importance of the modeling effect on future therapist-patient sexual contact. The research regarding sexual misconduct within other professional health care disciplines (other than physicians and psychologists) is insufficient, and limited research has been carried out regarding nonsexual boundary violations by health care professionals generally. In addition, few studies have examined boundary crossings by health care professionals or determined the effects experienced by the patient. Consequently, more research is required to develop and advance boundary theory in relation to personal and professional boundaries, boundary crossings, and boundary violations within the nurse-patient relationship.

Research Questions and Assumptions

As previously stated, the purpose of this research is to explore the attitudes and behaviours of Alberta nurses working in the mental health field towards professional boundaries, boundary crossings, and boundary violations within the nurse-patient relationship. To achieve this purpose, the following research question was posed:

What are the attitudes and behaviours of mental health nurses practicing in Alberta toward professional boundaries, boundary crossings, and boundary violations?

The two secondary research questions that were investigated are:

1. What is the association between age, gender, marital status, years of experience in mental health nursing, and type of nursing education and the attitudes and behaviours of nurses toward professional boundaries, boundary crossings, and boundary violations?

2. What is the relationship between the area of specialty, area currently working, geographical location of the work place, the amount of time worked, and the attitudes and behaviours of nurses toward professional boundaries, boundary crossings, and boundary violations?

The following assumptions were identified:

1. There are significant gender differences in the attitudes and in the practice of nurses regarding boundary crossings and violations.

2. The geographical location of workplace, the area of nursing specialty, and the current work area will affect the incidence of professional boundary crossings and violations.

3. The nurse's level of education and experience will affect the incidence of professional boundary crossings and violations.

4. The nurses who commit serious boundary violations differ from their peers both in attitudes and behaviours.

The following null hypotheses were also identified:

1. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar attitudes toward the importance of understanding professional boundaries.

2. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, will have received some type of professional boundary education, and the types of education received will be similar in nature.

3. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar attitudes and behaviours around giving and receiving gifts when interacting with patients or clients.

4. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar attitudes and behaviours around personal disclosure when interacting with patients or clients.

5. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked,

have similar attitudes and behaviours around confidentiality and secrecy when interacting with patients or clients.

6. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar attitudes and behaviours around personal space when interacting with patients or clients.

7. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar attitudes and behaviours around dual relationships and sexual misconduct when interacting with patients or clients.

8. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar attitudes and behaviours around nurse-patient relationships.

9. All mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar interest in increasing their knowledge of professional boundaries.

CHAPTER THREE

METHODS AND PROCEDURES

Survey Research Design

It was assumed that nurses in Alberta would be interested in participating in research on professional boundaries. A descriptive survey research design utilizing a self-administered, mailed questionnaire with a majority of forced-choice, refined-response questions was selected. Closed questions tend to promote ease of coding and avoid the difficulties associated with writing, processing, and analyzing open-ended questions.

Target Population and Sample

The population targeted for this research included all nurses actively registered with a professional association working in the mental health field in Alberta. In the 1999/2000 registration year, there were 23,853 registered nurses (RNs) in Alberta actively registered with the Alberta Association of Registered Nurses (AARN) and 1,113 psychiatric nurses (RPNs) in Alberta actively registered with the Registered Psychiatric Nurses Association of Alberta (RPNAA). Of the 23,853 nurses registered with the AARN, 896 reported that psychiatry/mental health was their primary area of responsibility. The target population for this study was all 2,009 actively registered nurses working in the mental health field (896 RNs and 1,113 RPNs) in Alberta.

Data Collection Strategies

The questionnaire, covering letter, optional request card for survey results, and self-addressed, stamped return envelope was mailed to the home address of each of the 896 RNs and 1,113 RPNs. A follow-up reminder notice was sent after two weeks. The data collection took three months to complete.

To encourage the participants to complete and return the questionnaire, the survey was designed to be completed in less than 15 minutes. The topic of professional boundaries has recently gained prominence in the health care field and was thought to be of interest to nurses in Alberta. Another strategy utilized to ensure that the questionnaire would be more likely to be completed was to design a professional-appearing questionnaire that was attractively spaced, easy to read, and uncluttered. It was also helpful to inform participants that a summary of the finished study would be available to them upon request. A response rate of approximately 30% was expected. See Appendix F.

Financial support to partially cover the cost of printing and postage was obtained from the Grey Nuns Community Hospital through the Caritas Research Steering Committee. As well, support in principle and assistance in mailing out the survey was pursued through the Alberta Association of Registered Nurses and the Registered Psychiatric Nurses Association of Alberta.

Data Analysis

The survey data were analyzed using SPSS 10.0. Because the research was essentially descriptive and evaluative in nature, the data analysis was carried out in an exploratory manner, involving examination of basic frequency and percentage distributions, cross tabulations, and one-way analyses of variance (ANOVA). Cross tabulations produce tables that allow the researcher to distinguish the effects of levels of an independent variable on a dependent variable. Basic cross tabulations are considered an essential starting point for any data analysis. Other more sophisticated statistical procedures allow the researcher to be more precise about the findings. A one-way ANOVA is a statistical test used for simultaneously testing differences between means from independent variables that have more than two groups. ANOVAs have a known sampling distribution (F-Distribution) and can be used for large sample sizes. The findings are summarized and presented in Chapter Four.

Ethical Considerations

Prior to the implementation of the study, approval was obtained from the Health Research Ethics Board and the Faculty of Nursing at the University of Alberta. The covering letter that was sent out with the questionnaire included (a) the name of the organizations and investigator involved in the study, (b) a description of the purpose of the study, (c) a description of the data-collection method, and (d) an explanation of the way in which the data would be utilized. The covering letter emphasized that participation in the study was voluntary and that the respondent could skip any question that he or she felt uncomfortable in answering. The participants consented to the study by returning a completed questionnaire. The participant could request a summary of the finished study by mailing in a separate optional request form. The potential participants were also informed that the data might be utilized for another research study in the future, subject to appropriate ethical approval.

It was not anticipated that there would be any harm or negative consequences to the subjects participating in the study. The main intrinsic benefit to the participants was the perception that they had contributed to a worthwhile research project. More direct benefits such as payment or services were not utilized.

To ensure confidentiality and anonymity, only the investigator involved in the research had access to the data. The participants' names did not appear on the questionnaire, and the investigator had no access to the membership mailing lists of the professional associations. Private mailing firms were utilized for the mail-outs. The results are reported in a manner that prevented the identification of specific participants.

Strengths and Weaknesses of the Design

The written, mailed questionnaire was less expensive in terms of time and money than other designs. The cost of printing the questionnaire was relatively inexpensive, whereas the cost of postage was prohibitive. The training and travel costs of field interviewers can be excessive and were avoided in the mailed questionnaire. A large amount of data over a range of professional boundary topics was collected. The large samples, covering a large geographical area, compensated for the expected low return rate. It was hoped that participants would feel a greater sense of anonymity and would be more willing to share attitudes and behaviours that were of a sensitive nature. The predetermined format was standard for all participants and was not influenced by the investigator, thus minimizing interviewer bias and error.

It was assumed that the subjects had an appropriate literacy rate in order to be able to answer the questions. Care was taken in the wording of the questions to ensure that they were clear, brief, and applicable. The responses of the participant could not be observed, and questions could not be clarified if they were misunderstood. Therefore, the questions were carefully constructed to ensure that they were not (a) double barrelled, (b) double negative, (c) leading, (d) inappropriate, (e) overly complex, or (f) biased. Because the majority of the questions were forced choice or fixed response, the respondents were unable to elaborate on their answers; and therefore, indepth data were not obtainable. Nonresponse to questions could be problematic and lead to bias.

Reliability and Validity of Measures

Errors in the measurement process can be either constant or random. A *constant* error will consistently affect the measurement of the variable in the same way each time a measurement is completed. The two most common constant errors that would have been problematic for the questionnaire were social desirability (the tendency of the respondents to give a favourable picture of themselves) and acquiescent response set (tendency of the respondents to agree or disagree with a statement regardless of its content, especially when presented with a series of statements). Social desirability tends to be less problematic when a self-administered questionnaire is used. *Random* error is unpredictable error that varies from one measurement to another although the characteristic being measured has not changed. Random errors directly affect reliability and indirectly affect validity of the measurement. Random errors can result from the participant, the environment, the wording of the questions, and the process of data analysis (errors in coding).

Validity refers to the issue of control in research designs and allows the researcher to know whether the measurement that he or she is utilizing is measuring what it was intended to measure. *Internal* validity is the extent to which the results of the study can actually be attributed to the action of the independent variable and not something else (B occurred because of what you did to A). *External* validity refers to the degree to which the findings of the sample are generalizable to the target population. Face validity is appropriate when there is little or no prior research literature to which to refer. Experts in the mental health field (including a psychiatrist, psychologist, occupational therapist, social worker, three nurse managers, three nurse educators, and three staff nurses) were asked to validate the questionnaire for content, clarity, appropriateness, and the length of time taken for completion. The content validity of the questionnaire was established by comparing the content of the questions to the literature on boundaries.

CHAPTER FOUR

RESULTS

Since the early 1970s a number of studies have addressed sexual boundary violations by physicians and psychologists, and mental health professionals now recognize that sexual boundary violations are harmful to the patient or client. More recently, it has been acknowledged that boundary crossings and other nonsexual boundary violations may also be detrimental to the patient or client. Nurses require a clear understanding of professional boundaries and the underlying principles involved to be able to identify boundary crossings and violations that may be harmful to the patient, the nurse, and the nurse-patient relationship. Personal and professional boundaries, boundary crossings, and boundary violations as they relate to boundary theory and the nurse-patient relationship have not been well studied in the nursing literature. To explore the attitudes and behaviours concerning professional boundaries, boundary crossings, and boundary violations within the nurse-patient relationship, a descriptive survey of the Alberta population of practicing mental health nurses was carried out. The results of the quantitative data were structured in relation to the participants' reported knowledge of professional boundaries and their attitudes and behaviours around boundary crossings and boundary violations. The frequencies, cross tabs, and one-way analyses of variance have been completed from the data and are included in this chapter.

Description of the Respondents

In the spring of 2000, the survey on professional boundaries was mailed to all Alberta mental health nurses registered with the Registered Psychiatric Nursing Association of Alberta (RPNAA) and the Alberta Association of Registered Nurses (AARN). Of the total 2,009 surveys mailed, 1,113 were sent to registered psychiatric nurses (RPNs) (the entire RPNAA membership) and 896 were sent to registered nurses (RNs), those who indicated when registering that their primary area of responsibility was mental health/psychiatry. The surveys were sent out through the mailing services of the RPNAA and AARN, and the author had no knowledge of the names on the mailing lists. A response rate of 45.94% was obtained, with a total of 923 surveys returned. Thirty-seven surveys (1.84%) were returned due to incorrect addresses. None of the surveys were defaced or spoiled. One of the returned surveys was a photocopy with half of the questions and responses missing. See Appendix F.

Participant Demographic Profile

Education

Of the 923 respondents who participated in the survey, 441 indicated that they were RPNs, 476 were RNs, and 6 did not answer the question. The vast majority (430) of the 441 RPNs who responded indicated that their highest educational preparation in nursing was a diploma in psychiatric nursing. Eight RPNs held an Advanced Diploma in Mental Health, and 3 held a Bachelor of Science in Mental Health degree. Of those RPNs who indicated educational preparation other than nursing, 64 had a certificate, 204 a diploma, 44 an undergraduate degree, 7 a master's degree, 1 a PhD, and 1 indicated some other type of educational preparation.

A diploma in nursing was held by 253 of the 476 RNs who had responded to the survey. Three of the RNs who attained a diploma in nursing had also earned a Post Basic Mental Health Certificate, and 37 indicated that they were prepared at both the diploma RN and diploma RPN level. A degree in nursing was obtained by 156 RNs, and 3 individuals earned both a degree in nursing and a psychiatric nursing diploma. Twenty-four RNs indicated that their highest educational preparation in nursing was a graduate degree, with 23 participants achieving a master's degree and 1 participant a PhD. Of those RNs who indicated educational preparation other than nursing, 60 had a certificate, 164 a diploma, 60 a degree, 8 a masters, and 4 a PhD. None of the participants indicated any other type of educational preparation. Table B1 in Appendix B shows the educational background of the respondents.

Gender, Age, and Marital Status

Most of the respondents were women (83.4%), with men making up 15.8%. Gender was not indicated by 0.8% of the participants. The median age of the respondents was 45. Nurses over the age of 40 made up 65.2% of the participants. Of the respondents, 5.6% (female 50, male 2) were between the ages of 21 and 30, 27.1% (female 216, male 33) were between the ages of 31 and 40, 36.6% (female 277, male 59) were between the ages of 41 and 50, 25.6% (female 194, male 42) were between the ages of 51 and 60, and 3.0%

(female 22, male 6) were between the ages of 61 and 70. Nineteen of the participants did not indicate their age, and 7 did not indicate their gender.

The majority of the respondents were married (68.0%). Of the remaining mental health nurses, 13.5% were separated or divorced, 8.9% were single, 7.7% were living common law, and 1.3% were widowed. Table B1 in Appendix B illustrates the age, gender, and marital status of the respondents.

Participant Work History

Years Working in Mental Health Nursing

The nurses in this survey had worked an average of 16.2 years in the mental health field. The number of years worked ranged from 0 to 47. Twenty-four nurses did not answer this question. Table C1 in Appendix C shows the years worked in mental health nursing.

Place and Location of Employment

The majority of the respondents worked in an acute care hospital (48.3%), community/outpatient program (23.0%), or provincial institution (19.9%). The remainder of the respondents worked in a nursing home/continuing care facility (5.9%), private practice (3%), private agency (2.3%), clinic/physicians office (1.3%), Home Care (1.1%), university/college (1.7%), or school (0.4%). Other places of employment were reported by 7.5% of the participants. These areas were not mutually exclusive because the respondents often worked in more than one setting. Most of the respondents worked in a city (76.6%). The remainder of the respondents worked in a town (15.8%), a rural area (2.8%), or in a village or hamlet (0.4%). Table C1 in Appendix C indicates the respondents' place and location of employment.

Clinical Area

The respondents also indicated the clinical areas in which they currently worked and the areas in which they had worked in the past. These areas were not mutually exclusive because the respondents often worked in more than one area and in more than one setting. Most of the respondents reported current employment in adult psychiatry (48.0%). The remainder worked in geriatric (15.4%), child and adolescent (8.2%), or forensic psychiatry (5.3%). Of the participants, 139 (15.1%) indicated employment in other types of work, 3.7% indicated group therapy, and 2.3% reported that they did not have a current work area. The respondents in this survey had worked an average of 10.6 years in their current work area, and the number of years worked ranged from 0 to 47. Thirty-five nurses did not answer this question. Table D1 in Appendix D indicates the respondents' current work area and the years worked in that area.

Of the areas worked in the past, the majority of the respondents had been employed in adult (73.0%) or geriatric psychiatry (56.7%). The remainder had worked in group therapy (35.8%), child and adolescent (34.5%), or forensic psychiatry (24.4%). Employment in other areas of nursing was indicated by 15.4% of the participants, and 5.5% of the respondents did not have a past work area. These areas were not mutually exclusive because the respondents had often worked in more than one area and in more than one setting. Table D1 in Appendix D shows the areas in which the respondents had worked in the past.

The respondents also identified their areas of specialty in mental health nursing. Again, most of the respondents indicated that their specialty area was adult psychiatry (49.3%). The remainder indicated that their specialty was geriatric (14.7%), child and adolescent (8.0%), or forensic psychiatry (4.6%). Eighty-seven of the respondents indicated a specialty in some other area, 4.3% indicated group therapy, and 5.6% reported that they did not have a specialty work area. Table D1 in Appendix D indicates the respondents' area of specialty.

Position Title, Position Type, and Amount of Time Worked

The majority of the respondents worked as staff nurses (74.8%). Charge nurses and team leaders made up 9.9% and head nurses/assistant head nurses made up 0.8%. The position title of manager/assistant manager was reported by 4.8% of the participants, director and assistant director 1.4%, and administrator 0.4%. Consultants made up 5.4%, educators and clinical specialists 4.9%, and professors 0.3% of the participants. Other position titles were reported by 15.8% of the respondents. These areas were not mutually exclusive because the respondents often worked in more than one position.

Most of the survey participants were employed in permanent positions (79.1%). The remainder of the respondents were employed in casual (15.2%), temporary (5.3%), contract (2.9%), or other (3.4%) positions. Two percent of the respondents were self-employed. These areas were not mutually exclusive because respondents often worked in more than one position.

The respondents were also asked about the amount of time that they worked. Of the 909 participants who responded, 51.2% worked full-time, 38.7%

worked part-time, and 6.8% worked more than full-time. Table E1 in Appendix E indicates the respondents' position title, position type, and amount of time worked.

Knowledge of Professional Boundaries

Attitudes Toward the Importance of Professional Boundaries

As a measure of the general importance that metal health nurses practicing in Alberta placed on professional boundaries, the respondents were asked questions about how important it was to (a) understand what professional boundaries are, (b) understand their own personal boundaries, (c) know their professional code of ethics, (d) establish professional boundaries with patients, and (e) maintain professional boundaries with patients. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables of the importance of professional boundaries were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

Of the participants who responded to the survey, 98.5% indicated that it was very or somewhat important to understand professional boundaries, 98.7% that it was very or somewhat important to understand their own boundaries, 97.1% that it was very or somewhat important to know their code of ethics, 97.8% that it was very or somewhat important to establish boundaries with patients, and 97.8% that it was very or somewhat important to maintain boundaries with patients. Table 1 summarizes the importance that the respondents placed on the knowledge, establishment, and maintenance of personal and professional boundaries.

Table 1

Importance of Professional Boundaries

Rating of Frequency	Frequency	Percentage
Understand Professional Boundaries		
Very important	827	89.6
Somewhat important	82	8.9
Neutral	9	1.0
Somewhat unimportant	1	0.1
Not at all important	0	0
No response	4	0.4
Understand Own Boundaries		
Very important	835	90.5
Somewhat important	76	8.2
Neutral	4	0.4
Somewhat unimportant	1	0.1
Not at all important	1	0.1
No response	6	0.7
Know Code of Ethics		
Very important	785	85.0
Somewhat important	112	12.1
Neutral	19	2.1
Somewhat unimportant	0	0
Not at all important	0	0
No response	7	0.8
Establish Boundaries with Patients		
Very important	807	87.4
Somewhat important	96	10.4
Neutral	14	1.5
Somewhat unimportant	0	0
Not at all important	0	0
No response	6	0.7

(table continues)

Rating of Frequency	Frequency	Percentage
Maintain Boundaries with Patients		
Very important	809	87.6
Somewhat important	94	10.2
Neutral	13	1.4
Somewhat unimportant	1	0.1
Not at all important	0	0
No response	6	0.7

Note. Frequencies may not add up to 923 (total n) due to nonresponses for specific variables.

The data were examined to determine if there was a relationship between the respondents' *age* and their attitudes toward the importance of professional boundaries. The one-way analysis of variance (ANOVA) was utilized to determine the differences between the means of the independent variable of the nurse's age and the nurses' attitudes toward the importance of professional boundaries. The null hypothesis that all respondents, regardless of age, have similar attitudes concerning the importance of professional boundaries was tested. The results indicated that a significant result based on age was obtained for the variable of the importance of establishing professional boundaries with patients or clients. Therefore, in the case of age, the null hypothesis that the nurses' age has no effect on their attitudes toward the importance of understanding professional boundaries was rejected.

A second ANOVA was carried out to determine if there was a relationship between the respondents' *gender* and attitudes toward the importance of professional boundaries. The null hypothesis that the nurses' gender has no effect on their attitudes toward the importance of professional boundaries was rejected. The results indicated that a significant result based on gender was obtained for the variables of the importance of understanding own personal boundaries and the importance of maintaining professional boundaries with patients or clients.

The data were also examined to determine if there was a significant relationship between the respondents' *marital status* and their attitudes toward the importance of professional boundaries. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar attitudes toward the importance of professional boundaries was accepted.

The data were then examined to determine if there was a significant relationship between the respondents' *nursing education* and their attitudes toward the importance of professional boundaries. The ANOVA results indicated that there was a significant difference in the respondents' attitudes toward understanding what professional boundaries are, based on their nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar attitudes regarding the importance of professional boundaries was rejected.

The data were also examined to determine if there was a significant relationship between the respondents' *years of experience* working in mental health nursing and their attitudes toward the importance of professional boundaries. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar attitudes toward the importance of professional boundaries was accepted.

The data were then examined to determine if there was a significant relationship between the *specialty area* of the respondents and their attitudes toward the importance of professional boundaries. There was a significant difference in the respondents' attitudes, as shown in the ANOVA, toward the importance of establishing professional boundaries with patients or clients and maintaining professional boundaries with patients or clients based on the specialty area of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar attitudes toward the importance of professional boundaries was rejected.

The data were also examined to determine if there was a significant relationship between the respondents' *current work area* and their attitudes toward the importance of professional boundaries. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar attitudes toward the importance of professional boundaries was accepted.

The data were then examined to determine if there was a significant relationship between the *workplace location* of the mental health nurses and their attitudes toward the importance of professional boundaries. There was a significant difference in the respondents' attitudes, as shown in the ANOVA, toward the importance of establishing professional boundaries with patients or clients and maintaining professional boundaries with patients or clients based on the workplace location of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar attitudes toward the importance of professional boundaries was rejected.

The data were then examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their attitudes toward the importance of professional boundaries. There was a significant difference in the respondents' attitudes, as shown in the ANOVA, toward the importance of understanding their own professional boundaries based on the amount of time worked. Therefore, the null hypothesis that all respondents, regardless of amount of time worked, have similar attitudes toward the importance of professional boundaries was rejected.

In summary, in an examination of the importance of understanding professional boundaries, the null hypotheses that all mental health nurses, regardless of (a) marital status, (b) years of experience, and (d) current work area, have similar attitudes toward the importance of understanding professional boundaries were accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) gender, (d) nursing education, (e) specialty area, (f) workplace location, and (g) amount of time worked, have similar attitudes toward the importance of understanding professional boundaries were rejected.

Professional Boundary Education

To identify the professional boundary education that the respondents had previously received, the survey participants were asked if they had ever received any education in the area of professional boundaries. They were also requested to identify where they had obtained the information regarding professional boundaries. They were asked to report if they had received information about professional boundaries (a) in a diploma program, (b) in a baccalaureate program, (c) in a graduate program, (d) through the workplace, (e) through a professional association, (f) through conferences or workshops, or (g) through other ways. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, and the dependent variables of professional boundary education were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

Of the respondents, 79.5% reported that they had received some type of education in the area of professional boundaries. When asked where they had received the information about professional boundaries, 48.9% of the respondents stated that they had received information in their diploma program, 14.0 % in a baccalaureate program, and 4.9% in a graduate program. A number of the respondents had also received information through their workplace (50.1%), their professional association (26.8%), and conferences and workshops (40.1%). Other sources of information were indicated by 7.5% of the respondents. These areas were not mutually exclusive, because the respondents may have received education in one or more educational or work setting. Table 2 summarizes the respondents' education in professional boundaries.

Table 2

Professional Boundary Education

Value	N	% of Respondents
Any Type of Professional Boundary Education*		
Yes	734	79.5
No	183	19.8
No response	6	0.7
Attained Information in a Diploma Program**		
Mentioned	451	48.9
Not mentioned	282	30.6
Skip value	182	19.7
No response	8	0.9
Attained Information in a Baccalaureate Program**		
Mentioned	129	14.0
Not mentioned	604	65.4
Skip value	182	19.7
No response	8	0.9
Attained Information in a Graduate Program**		
Mentioned	45	4.9
Not mentioned	688	74.5
Skip value	182	19.7
No response	8	0.9
Attained Information Through the Workplace**		
Mentioned	462	50.1
Not mentioned	271	29.4
Skip value	182	19.7
No response	8	0.9
Attained Information Through a Professional Association**		
Mentioned	247	26.8
Not mentioned	486	52.7
Skip value	182	19.7
No response	8	0.9

(table continues)

Value	N	% of Respondents
Attained Information Through the Conferences and Workshops**		
Mentioned	370	40.1
Not mentioned	363	39.3
Skip value	182	19.7
No response	8	0.9
Attained Information in Other Ways**		
Mentioned	69	7.5
Not mentioned	664	71.9
Skip value	182	19.7
No response	8	0.9

Note. *Frequencies may not add up to 923 (total n) due to nonresponses for specific variables and skip questions.
**Frequencies may add up to more than 923 as nurses often obtain professional boundary education in more than one place.

As the importance of professional boundaries has come to the forefront in recent years, the data were then examined to determine if there was a relationship between the respondents' *age* and the attainment of any type of education in the area of professional boundaries. There was a significant difference in the respondents' attainment of professional boundary education based on the age of the mental health nurse, as shown in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of age, have received similar professional boundary education was rejected.

It was also expected that younger nurses would be more likely to receive instruction on professional boundaries in their formal education programs. The cross tabulation results indicated that respondents in the age group of 61 to 70 were less likely to report that they had received information in a diploma program

(28.6%) than were other age groups (43.1% to 52.2%). Conversely, nurses who were in the age group of 21 to 30 were more likely to indicate that they had received information in a baccalaureate program (49.0%) than were the other age groups (7.1% to 14.5%). The respondents most likely to report that they had received information through their professional association and through conferences and workshops were those nurses aged 51 to 60 and 61 to 70. As well, there was a significant difference, as shown in the ANOVA, between the ages of the respondent who had received information about professional boundaries in a baccalaureate program, through their professional association, or through conferences or workshops. Therefore, the null hypothesis that the respondents, regardless of age, have received similar types of professional boundary education was rejected.

The data were also examined to determine if there was a significant relationship between the respondents' *gender* or *marital status* and any type of education in the area of professional boundaries. Specific types of education were also examined. No significant relationships were found in the ANOVAs. Therefore, the null hypotheses that the participants, regardless of gender or marital status, have similar types of education in the area of professional boundaries were accepted.

The data were then examined to determine if there was a relationship between the respondents' *education in nursing* and the acquisition of any type of education in the area of professional boundaries. There was no significant difference in the respondents' attainment of any type of professional boundary education, as shown by the ANOVA. Therefore, the null hypothesis that there was no difference in the respondents' method of attaining professional boundary education, regardless of nursing education, was accepted.

The data were then examined to determine if there was a relationship between the respondents' *education in nursing* and the acquisition of specific types of education in the area of professional boundaries. The cross tabulation results indicated that slightly more than half of the respondents graduating with a diploma (RN: 55.5%; RPN: 53.6%), 61.9% of those prepared at the baccalaureate level, and 52.2% prepared at the master's level had some instruction in the area of professional boundaries through their formal educational programs. These areas were not mutually exclusive because some respondents had completed educational preparation in nursing through both diploma and degree programs. There was a significant difference in the ANOVA results between the nursing education of the respondent and those who had received information about professional boundaries in a baccalaureate program, a graduate program, or through other ways. Therefore, the null hypothesis that the respondents, regardless of nursing education, have received similar professional boundary education was rejected.

The data were then examined to determine if there was a relationship between the respondents' *years of experience* working in mental health nursing and the attainment of any type of education in the area of professional boundaries. No significant relationships were found in the ANOVA. Therefore, the null hypothesis that the nurses' years of experience working in mental health had no effect on the attainment of any type of professional boundary education was accepted.

The data were then examined to determine if more recent graduates (those with fewer years of experience) were more likely to receive instruction on professional boundaries in their formal nursing education programs. Conversely, it was anticipated that the respondents with more *years of experience* would be more likely to report that they had received professional boundary education through methods other than formal nursing education programs. Another cross tabulation was completed on years of experience in mental health nursing and the attainment of education in the area of professional boundaries. The cross tabulation results indicated that the nurses with 0 to 10 years of experience (22.6%) were a little more likely to have received information regarding professional boundaries in their baccalaureate program than were those nurses in the 11 to 20-year group (11.8%) or the 21 to 30-year group (10.5%). There was little difference between the nurses' years of experience and the likelihood of receiving professional boundary education in a diploma program. Similar to the results obtained when the variable of age was examined, respondents with 21 to 30 or 31 to 40 years of experience were more likely to have received professional boundary education through their professional Association or through conferences and workshops. There was a significant difference, as shown in the ANOVA, between the years of experience of the respondents and those nurses who had received information about professional boundaries in a baccalaureate program, in a graduate program, through a professional association, or through conferences or workshops. Therefore, the null hypothesis that all respondents, regardless of years of experience, have received similar professional boundary education was rejected.

The data were then examined to determine if there was a relationship between the respondents' *specialty area* and the acquisition of any type of education in the area of professional boundaries. The cross tabulation results indicated that the mental health nurse specializing in geriatric nursing was less likely to have obtained any type of education in the area of professional boundaries (68.4%). The nurses specializing in the areas designated as other were the most likely to indicate that they had obtained some type of education in professional boundaries (87.2%). As well, there was a significant difference, as shown in the ANOVA, in the respondents' attainment of any type of professional boundary education according to specialty area. Therefore, the null hypothesis that there was no difference in the respondents' attainment of professional boundary education, regardless of specialty area, was rejected.

The data were then examined to determine if there was a relationship between the respondents' *specialty area* and the acquisition of specific types of education in the area of professional boundaries. The cross tabulation results indicated that respondents specializing in forensic nursing were the most likely (64.3%) to report that they had received professional boundary education in a diploma program. Nurses specializing in child and adolescent mental health nursing were the least likely (38.4%) to report such education in a diploma program. Respondents specializing in group therapy (66.7%) and forensic nursing (61.9%) were the most likely to receive professional boundary education through the workplace, and nurses specializing in geriatric nursing were the least likely (39.7%). Nurses specializing in group therapy were also more likely to report professional boundary education through conferences and workshops (71.8%) than were nurses who reported that they were not currently working (26.9%). These areas were not mutually exclusive, because some respondents had completed education in professional boundaries through more than one method. There was, as well, a significant difference, as shown in the ANOVA, between the specialty area of the mental health nurse and the methods of receiving information about professional boundaries through a diploma program, a baccalaureate program, a graduate program, through the workplace, through a professional association, through conferences or workshops, or through other ways. Therefore, the null hypothesis that the respondents, regardless of specialty area, have received similar professional boundary education was rejected.

Another cross tabulation was carried out on the variables of *current work area* and the attainment of any type of education in professional boundaries. The results indicated that the mental health nurses working in the area of group therapy (91.2%) and forensic nursing (87.8%) were most likely to report any type of professional boundary education. Those nurses working in the area of geriatric nursing were the least likely to report any type of professional boundary education (69.0%) than were nurses working in other areas. As well, there was a significant difference, as shown in the ANOVA, in the respondents' attainment of any type of professional boundary education according to the current work area.

Therefore, the null hypothesis that the respondents, regardless of current work area, have received similar professional boundary education was rejected.

The data were then examined to determine if there was a relationship between the respondents' *current work area* and the acquisition of specific types of education in the area of professional boundaries. The cross tabulation results indicated that those nurses working in group therapy (76.5%) and forensic nursing (69.4%) were the most likely to obtain professional boundary education through their workplace, with those nurses working in geriatric nursing the least likely (37.3%). There was a significant difference shown in the ANOVA between the current work area of the mental health nurse and the methods of receiving information about professional boundaries through a diploma program, a baccalaureate program, a graduate program, through the workplace, through a professional association, through conferences or workshops, or through other ways. Therefore, the null hypothesis that the respondents, regardless of current work area, have received similar professional boundary education was rejected.

It was anticipated that nurses working in smaller or rural centres would not have the same access to professional boundary information, as would the nurses working in larger or urban areas. The data were then examined to determine the relationship between the respondents' *workplace location* and the acquisition of any type of education in the area of professional boundaries. The cross tabulation results indicated that the mental health nurses working in a village or hamlet were much less likely to have received any type of professional boundary education. This finding should be interpreted with caution because only four participants indicated that they worked in a village or hamlet. There was a significant difference, as shown in the ANOVA, between the workplace locations of the mental health nurse and the method of attaining any type of professional boundary education. Therefore, the null hypothesis that there was no difference in the method of attaining professional boundary education regardless of workplace location was rejected.

The data were then examined to determine if there was a relationship between the respondents' *workplace location* and the acquisition of specific types of education in the area of professional boundaries. There was a significant difference, as shown in the ANOVA, between the workplace location of the mental health nurse and the methods of receiving information about professional boundaries through a baccalaureate program, a graduate program, through the workplace, through a professional association, through conferences or workshops, or through other ways. Therefore, the null hypothesis that the respondents, regardless of workplace location, have received similar professional boundary education was rejected.

The data were also examined to determine if there was a significant relationship between the *amount of time worked* by the mental health nurse and any type of professional boundary education. Specific types of education were also examined. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have received similar professional boundary education was accepted.

In summary, in an examination of the participants' attainment of any type of professional boundary education, the null hypotheses that all mental health nurses, regardless of (a) gender, (b) marital status, (c) nursing education, (d) years of experience, and (e) amount of time worked, have received some type of professional boundary education were accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) specialty area, (c) current work area, and (d) workplace location, have received some type of professional boundary education were rejected. As well, the null hypotheses that all mental health nurses' methods of attaining professional boundary education, regardless of (a) gender, (b) marital status, and (c) amount of time worked, were similar were accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) nursing education, (c) years of experience, (d) specialty area, (e) current work area, and (f) workplace location, have received similar methods of professional boundary education were rejected.

Interest in Increasing Professional Boundary Knowledge

The respondents in this survey were asked how interested they were in increasing their knowledge of professional boundaries. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) area of specialty, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables concerning the interest in increasing professional boundary knowledge were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

When the respondents were asked how interested they were in increasing their knowledge in the area of professional boundaries, 69.2% indicated that they were very or somewhat interested, 14.4% were a little interested, and 10.5% were not at all interested. Fifty-four nurses (5.9%) did not answer the question. Table 3 displays the respondents' interest in increasing their knowledge in professional boundaries.

Table 3

Interest in Increasing Professional Boundary Knowledge

Value	N	% of Respondents
Interested in Increasing Professional Boundary Knowledge		
Very	291	31.5
Somewhat	348	37.7
A little	133	14.4
Not at all	97	10.5
No response	54	5.9

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were examined to determine if there was a significant relationship between the (a) *age*, (b) *gender*, (c) *marital status*, (d) *nursing education*, (e) *years of experience*, (f) *area of specialty*, (g) *current work area*, (h) *workplace location*, and (i) *amount of time worked* by the respondents and their attitudes toward increasing their professional boundary knowledge. No significant relationship was found in the ANOVAs. Therefore, the null hypotheses that the respondents, regardless of age, gender, marital status, nursing education, years of experience, specialty area, current work area, workplace location, and amount of time worked, have similar attitudes toward increasing their professional boundary knowledge were accepted.

Boundary Crossings

Gift Giving

To determine the norms of gift giving in a mental health setting, the respondents in this survey were asked questions about their attitudes and behaviours toward giving and receiving gifts. The respondents were asked if there were times when it was appropriate to (a) lend money to patients and clients, (b) borrow money from patients or clients, (c) accept gifts of under $20 from patients or clients, (d) accept gifts of over $20 from patients or clients, (e) give gifts of under $20 to patients or clients, and (f) give gifts of over $20 to patients or clients. The survey participants were also asked about their behaviour regarding gift giving, including how often they had (a) lent money to patients or clients, (b) borrowed money from patients or clients, (c) accepted gifts of under $20 from patients or clients, (d) accepted gifts of over $20 from patients or clients, (e) given gifts of under $20 to patients or clients, and (f) given gifts of over $20 to patients or clients. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables of gift-giving attitudes and gift-giving behaviours was determined by cross tabulations. Probability values were generated using a one-way analysis (ANOVA) of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

Gift-Giving Attitudes

The vast majority of the respondents (96.9%) felt strongly that it was not appropriate to borrow money from patients or clients. As well, the majority of the respondents (57.6%) strongly disagreed that it was appropriate to lend money to patients or clients. When asked if it was appropriate, when providing patient care, to accept gifts of both under and over $20, 40.6% of the respondents indicated that they strongly disagreed that it was appropriate to accept gifts of under $20, and 81.4% indicated that they strongly disagreed that it was appropriate to accept gifts of over $20. Similarly, the respondents felt strongly that it was not appropriate to give gifts of under $20 (53.0%) or to give a gift of over $20 (81.7%). Table 4 illustrates the respondents' attitudes towards gift giving.

Table 4

Gift-Giving Attitudes

Rating of Frequency	Frequency	Percentage
OK to Lend Money To Patients		
Strongly disagree	532	57.6
Disagree somewhat	165	17.9
Neutral	131	14.2
Agree somewhat	60	6.5
Strongly agree	20	2.2
No response	15	1.6

(table continues)

Rating of Frequency	Frequency	Percentage
OK to Borrow Money From Patients		
Strongly disagree	894	96.9
Disagree somewhat	11	1.2
Neutral	1	0.1
Agree somewhat	0	0
Strongly agree	8	0.9
No response	9	1.0
OK to Accept Gifts Under $20		
Strongly disagree	375	40.6
Disagree somewhat	172	18.6
Neutral	238	25.8
Agree somewhat	100	10.8
Strongly agree	27	2.9
No response	11	1.2
OK to Accept Gifts Over $20		
Strongly disagree	751	81.4
Disagree somewhat	89	9.6
Neutral	44	4.8
Agree somewhat	14	1.5
Strongly agree	13	1.4
No response	12	1.3
OK to Give Gifts Under $20		
Strongly disagree	489	53.0
Disagree somewhat	150	16.3
Neutral	167	18.1
Agree somewhat	81	8.8
Strongly agree	27	2.9
No response	9	1.0
OK to Give Gifts Over $20		
Strongly disagree	754	81.7
Disagree somewhat	96	10.4
Neutral	43	4.7
Agree somewhat	8	0.9
Strongly agree	12	1.3
No response	10	1.1

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were examined to determine if there was a relationship between the respondents' *age* and their attitudes toward gift giving. The cross tabulation shows that the nurses in the age group of 21 to 30 years were slightly more likely to report that they strongly or somewhat agreed that it was appropriate to accept gifts of under $20 from patents or clients (25.0%) than were the nurses in the other age groups (11.5% to 14.3%). There was a significant difference in the attitudes of the respondents, as shown in the ANOVA, toward the appropriateness of accepting gifts of under $20 from patients or clients based on their age. Therefore, the null hypothesis that the respondents, regardless of age, have similar attitudes toward gift giving was rejected. Table 5 illustrates the comparison of the gift-giving attitudes reported by the respondents based on age.

Table 5

Analysis of Variance for Gift-Giving Attitudes by Age

		F	
Source	**df**	**Age**	**Sig.**
OK to Lend Money To Patients			
Between groups	4	1.204	0.307
Within groups	884		
OK to Borrow Money From Patients			
Between groups	4	0.701	0.592
Within groups	890		
OK to Accept Gifts Under $20			
Between groups	4	2.505	0.041*
Within groups	889		

(table continues)

Source	df	F Age	Sig.
OK to Accept Gifts Over $20			
Between groups	4	0.824	0.510
Within groups	887		
OK to Give Gifts Under $20			
Between groups	4	0.573	0.682
Within groups	890		
OK to Give Gifts Over $20			
Between groups	4	1.076	0.367
Within groups	889		

Note. *$p < 0.05$.

A second cross tabulation was completed on the variable of *gender* and the attitudes of gift giving. Male nurses were slightly more likely (13.7%) to strongly or somewhat agree that it was appropriate to lend money to patients or clients than were female nurses (7.9%). There was a significant difference in the respondents' attitudes, as shown in the ANOVA, toward the appropriateness of lending money to patients or clients and giving gifts of over $20 to patients or clients based on their gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar attitudes toward gift giving was rejected. Table 6 indicates the comparison of the gift giving attitudes detailed by the respondents based on gender.

Table 6

Analysis of Variance for Gift-Giving Attitudes by Gender

Source	df	F Gender	Sig.
OK to Lend Money To Patients			
Between groups	1	9.306	0.002*
Within groups	899		
OK to Borrow Money From Patients			
Between groups	1	0.836	0.361
Within groups	905		
OK to Accept Gifts Under $20			
Between groups	1	1.519	0.218
Within groups	903		
OK to Accept Gifts Over $20			
Between groups	1	0.043	0.837
Within groups	902		
OK to Give Gifts Under $20			
Between groups	1	1.210	0.272
Within groups	905		
OK to Give Gifts Over $20			
Between groups	1	8.606	0.003*
Within groups	904		

Note. * $p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *marital status* and their attitudes toward gift giving. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar attitudes toward gift giving was accepted.

Another cross tabulation was completed on the variable of *nursing education* and the nurses' attitudes toward gift giving. Nurses prepared at the BScN and BN (25.3%) or MScN and MN (34.8%) level were more likely to strongly or somewhat agree that it was appropriate to accept gifts of under $20 from patients or clients than were nurses with an RN diploma (10.5%) or RPN diploma (11.3%). Nurses prepared at the RPN diploma level were the most likely to strongly disagree that it was appropriate to give gifts of under $20 to patients or clients (60.8%). Nurses prepared at the master's level were the least likely to strongly disagree that it was appropriate to give gifts of under $20 to a patient or client (39.1%). There was a significant difference in the respondents' attitudes, as shown in the ANOVA, toward the appropriateness of accepting gifts of under $20 from patients or clients and giving gifts of under $20 to patients or clients based on their nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, hold similar attitudes toward gift giving was rejected. Table 7 indicates the comparison of the respondents' attitudes toward gift giving based on nursing education.

Table 7

Analysis of Variance for Gift-Giving Attitudes by Nursing Education

Source	df	F Nursing Education	Sig.
OK to Lend Money To Patients			
Between groups	5	1.957	0.083
Within groups	896		
OK to Borrow Money From Patients			
Between groups	5	0.746	0.589
Within groups	902		
OK to Accept Gifts Under $20			
Between groups	5	8.734	0.000*
Within groups	900		
OK to Accept Gifts Over $20			
Between groups	5	1.553	0.171
Within groups	899		
OK to Give Gifts Under $20			
Between groups	5	3.443	0.004*
Within groups	902		
OK to Give Gifts Over $20			
Between groups	5	1.708	0.130
Within groups	901		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *years of experience* and their attitudes toward gift giving. There was a significant difference in the gift-giving attitudes of the mental health nurse, as shown in the ANOVA, towards the appropriateness of lending money to patients or clients based on years of experience. Therefore, the null hypothesis that the respondents, regardless years of experience, have similar attitudes toward gift giving was rejected. Table 8 indicates the comparison of the gift-giving attitudes reported by the respondents based on years of experience.

Table 8

Analysis of Variance for Gift-Giving Attitudes by Years of Experience

Source	df	F Years of Experience	Sig.
OK to Lend Money To Patients			
Between groups	4	2.468	0.043*
Within groups	880		
OK to Borrow Money From Patients			
Between groups	4	1.410	0.229
Within groups	886		
OK to Accept Gifts Under $20			
Between groups	4	1.500	0.200
Within groups	884		
OK to Accept Gifts Over $20			
Between groups	4	1.123	0.344
Within groups	883		
OK to Give Gifts Under $20			
Between groups	4	1.261	0.284
Within groups	886		
OK to Give Gifts Over $20			
Between groups	4	1.187	0.315
Within groups	885		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *specialty area* and their attitudes toward gift giving. The cross tabulations indicated that the participants specializing in group therapy (74.4%) were the most likely to report that they strongly disagreed that it was appropriate to lend money to patients or clients, whereas those not currently working (51.9%) and those working in other areas (52.9%) were the least likely to report that they strongly disagreed. The participants specializing in forensic nursing (66.7%) were the most likely to report that they strongly disagreed that it was appropriate to accept gifts of under $20 from patients or clients, whereas the nurses specializing in child and adolescent mental health (33.3%) were the least likely to report that they strongly disagreed that it was appropriate to do so. Those respondents who indicated that their area of specialty was forensic nursing (73.8%) or group therapy (70.0%) were the most likely to relate that they strongly disagreed that it was appropriate to give gifts of under $20 to patients or clients. The respondents specializing in the area of child and adolescent mental health nursing (42.5%) were, again, the least likely to strongly disagree that it was appropriate to give gifts of under $20 to patients or clients.

There was, as well, a significant difference in the gift-giving attitudes of the respondents, as shown in the ANOVA, toward the appropriateness of lending money to patients or clients, accepting gifts of under $20 from patients or clients, and giving gifts of under $20 to patients or clients based on the specialty area of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar attitudes toward gift giving was rejected. Table 9 reveals the comparison of the gift-giving attitudes reported by the respondents based on specialty area.

Table 9

Analysis of Variance for Gift-Giving Attitudes by Specialty Area

Source	df	F Specialty Area	Sig.
OK to Lend Money To Patients			
Between groups	6	3.297	0.003*
Within groups	866		
OK to Borrow Money From Patients			
Between groups	6	0.119	0.994
Within groups	872		
OK to Accept Gifts Under $20			
Between groups	6	4.553	0.000*
Within groups	871		
OK to Accept Gifts Over $20			
Between groups	6	0.913	0.484
Within groups	869		
OK to Give Gifts Under $20			
Between groups	6	4.129	0.000*
Within groups	872		
OK to Give Gifts Over $20			
Between groups	6	1.148	0.332
Within groups	871		

Note. * $p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *current work area* and their gift giving attitudes. The cross tabulations indicated that the participants who were currently working in group therapy (73.5%), child and adolescent mental health (73.3%), and forensic nursing (71.4%) were most likely to indicate that they strongly disagreed that it was appropriate to lend money to patients or clients. The nurses currently not working (33.3%) were the least likely to report that they strongly disagreed that it was appropriate to do so.

The respondents currently working in forensic nursing (59.2%) were the most likely to report that they strongly disagreed that it was appropriate to accept gifts of under $20 from patients or clients. The nurses who reported that they were currently not working (33.3%) or currently working in child and adolescent mental health (36.0%%) were the least likely to indicate that they strongly disagreed that it was appropriate to accept gifts of under $20 from patients or clients. The respondents currently working in forensic nursing (71.4%) or currently working in group therapy (70.6%) were the most likely to report that they strongly disagreed that it was appropriate to give gifts of under $20 to patients or clients. The nurses who reported that they were currently not working (38.1%) or currently working in child and adolescent mental health (46.7%) were the least likely to report that they strongly disagreed that it was appropriate to do so.

There was also a significant difference in the gift-giving attitudes of the respondents, as shown in the ANOVA, toward the appropriateness of lending money to patients or clients, accepting gifts of under $20 from patients or clients, and giving gifts of under $20 to patients or clients based on the current work area of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar attitudes toward gift giving was rejected. Table 10 displays the comparison of the gift-giving attitudes of the respondents based on current work area.

Table 10

Analysis of Variance for Gift-Giving Attitudes by Current Work Area

Source	**df**	**F** **Current Work Area**	**Sig.**
OK to Lend Money To Patients			
Between groups	6	4.871	0.000*
Within groups	883		
OK to Borrow Money From Patients			
Between groups	6	0.546	0.773
Within groups	889		
OK to Accept Gifts Under $20			
Between groups	6	3.084	0.005*
Within groups	887		
OK to Accept Gifts Over $20			
Between groups	6	0.765	0.598
Within groups	886		
OK to Give Gifts Under $20			
Between groups	6	2.611	0.016*
Within groups	889		
OK to Give Gifts Over $20			
Between groups	6	0.995	0.427
Within groups	888		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *workplace location* and their attitudes toward gift giving. There was a significant difference in the gift-giving attitudes of the respondents, as shown in the ANOVA, toward the appropriateness of accepting gifts of under $20 from patients or clients based on the workplace location of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar attitudes toward gift giving was rejected. Table 11 indicates the comparison of the gift-giving attitudes reported by the mental health nurse based on workplace location.

Table 11

Analysis of Variance for Gift-Giving Attitudes by Workplace Location

		F	
Source	**df**	**Workplace Location**	**Sig.**
OK to Lend Money To Patients			
Between groups	4	1.207	0.306
Within groups	863		
OK to Borrow Money From Patients			
Between groups	4	0.219	0.928
Within groups	869		
OK to Accept Gifts Under $20			
Between groups	4	2.957	0.019*
Within groups	867		
OK to Accept Gifts Over $20			
Between groups	4	1.703	0.147
Within groups	866		

(table continues)

		F	
Source	**df**	**Workplace Location**	**Sig.**
OK to Give Gifts Under $20			
Between groups	4	0.999	0.407
Within groups	869		
OK to Give Gifts Over $20			
Between groups	4	2.096	0.080
Within groups	868		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *amount of time* that the respondents worked and their attitudes toward gift giving. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar attitudes toward gift giving was accepted.

Gift-Giving Behaviours

When the respondents were asked about their gift-giving behaviours, the vast majority (97.6%) reported that they had never borrowed money from patients or clients, and 58.8% reported that they had never lent money to patients or clients. However, only 36.3% of the participants stated that they had never accepted gifts of under $20, and 92.4% of the respondents reported that they had never accepted gifts of over $20. When asked about their gift giving to patients or clients, 62.2% of the respondents reported that they had never given gifts of under $20, and 94.3% reported that they had never given gifts of over $20. Table 12 shows the respondents' behaviours towards gift giving.

Table 12

Gift-Giving Behaviours

Rating of Frequency	Frequency	Percentage
Lent Money To a Patient		
Never	543	58.8
Rarely	290	31.4
Sometimes	74	8.0
Often	6	0.7
Always	0	0
No response	10	1.1
Borrowed Money From a Patient		
Never	901	97.6
Rarely	13	1.4
Sometimes	0	0
Often	0	0
Always	1	0.1
No response	8	0.9
Accepted Gifts Under $20		
Never	335	36.3
Rarely	379	41.1
Sometimes	177	19.2
Often	14	1.5
Always	8	0.9
No response	10	1.1
Accepted Gifts Over $20		
Never	853	92.4
Rarely	48	5.2
Sometimes	10	1.1
Often	0	0
Always	1	0.1
No response	11	1.2

(table continues)

Rating of Frequency	Frequency	Percentage
Given Gifts Under $20		
Never	574	62.2
Rarely	227	24.6
Sometimes	93	10.1
Often	17	1.8
Always	3	0.3
No response	9	1.0
Given Gifts Over $20		
Never	870	94.3
Rarely	35	3.8
Sometimes	5	0.5
Often	3	0.3
Always	1	0.1
No response	9	1.0

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were then examined to determine if there was a significant relationship between the mental health nurses' *age* and their gift-giving behaviours. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of age, have similar gift-giving behaviours was accepted.

It was anticipated that there would be differences in the respondents' gift-giving behaviours when *gender* was considered. The cross tabulation indicated that the male respondents were more likely (17.8%) to report that they sometimes or often lent money to patients or clients, whereas only 7.1% of the female respondents reported that they did so. There was a significant difference, as shown in the ANOVA, in the respondents' gift-giving behaviours of lending money to patients or clients and accepting gifts of under $20 from patients or clients based on the gender of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of gender, have similar gift-giving behaviours was rejected. Table 13 indicates the comparison of the gift-giving behaviours of the mental health nurse based on gender.

Table 13

Analysis of Variance for Gift-Giving Behaviours by Gender

		F	
Source	**df**	**Gender**	**Sig.**
Lent Money to Patients			
Between groups	1	20.215	0.000*
Within groups	904		
Borrowed Money From Patients			
Between groups	1	1.326	0.250
Within groups	906		
Accepted Gifts Under $20			
Between groups	1	5.889	0.015*
Within groups	904		
Accepted Gifts Over $20			
Between groups	1	1.601	0.206
Within groups	903		
Given Gifts Under $20			
Between groups	1	2.171	0.141
Within groups	905		
Given Gifts Over $20			
Between groups	1	0.556	0.456
Within groups	905		

Note. $^{*}p < 0.05$.

The data were then examined to determine if there was a significant relationship between the respondents' *marital status* and their gift-giving behaviours. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar gift-giving behaviours was accepted.

The data were then examined to determine if there was a significant relationship between the respondents' *education in nursing* and their gift-giving behaviours. There was a significant difference, as shown in the ANOVA, in the respondents' gift-giving behaviours of lending money to patients or clients, accepting gifts of under $20 from patients or clients, and giving gifts of under $20 to patients and clients based on the nursing education of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar gift-giving behaviours was rejected. Table 14 outlines the comparison of the gift-giving behaviours reported by the respondents based on nursing education.

Table 14

Analysis of Variance for Gift-Giving Behaviours by Nursing Education

Source	df	F Nursing Education	Sig.
Lent Money To Patients			
Between groups	5	4.211	0.001*
Within groups	901		
Borrowed Money From Patients			
Between groups	5	0.765	0.575
Within groups	903		
Accepted Gifts Under $20			
Between groups	5	3.499	0.004*
Within groups	901		
Accepted Gifts Over $20			
Between groups	5	0.797	0.552
Within groups	900		
Given Gifts Under $20			
Between groups	5	5.470	0.000*
Within groups	902		
Given Gifts Over $20			
Between groups	5	0.875	0.497
Within groups	902		

Note. $^{*}p < 0.05$.

The data were then examined to determine if there was a significant relationship between the respondents' *years of experience* and their gift-giving behaviours. There was a significant difference, as shown in the ANOVA, in the respondents' gift-giving behaviours of lending money to patients or clients and giving gifts of under $20 to patients or clients based on the years of experience of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar gift-giving behaviours was rejected. Table 15 outlines the comparison of the gift-giving behaviours reported by the respondents based on years of experience.

Table 15

Analysis of Variance for Gift-Giving Behaviours by Years of Experience

Source	df	F Years of Experience	Sig.
Lent Money To Patients			
Between groups	4	3.038	0.017*
Within groups	885		
Borrowed Money From Patients			
Between groups	4	0.516	0.724
Within groups	887		
Accepted Gifts Under $20			
Between groups	4	2.190	0.068
Within groups	885		
Accepted Gifts Over $20			
Between groups	4	0.689	0.599
Within groups	884		
Given Gifts Under $20			
Between groups	4	2.783	0.026*
Within groups	886		
Given Gifts Over $20			
Between groups	4	0.758	0.553
Within groups	886		

Note. $^*p < 0.05$.

The data were then examined to determine if there was a significant relationship between the respondents' *specialty area* and their gift-giving behaviours. The cross tabulations indicated that respondents specializing in the area of forensic nursing were the most likely (78.6%) to report that they had never lent money to patients or clients. Nurses specializing in adult mental health nursing were the least likely (53.2%) to report that they had never lent money to patients or clients. Similar to the results obtained when comparing gift-giving attitudes, the nurses specializing in forensic nursing were the most likely (66.7%) to report that they had never accepted gifts of under $20 from patients or clients. Similarly, nurses specializing in child and adolescent mental health were the least likely (23.3%) to report that they had never accepted gifts of under $20 from patients or clients. When asked about their practices in giving gifts of under $20 to patients or clients, the nurses specializing in forensic nursing were again the most likely to report that they had never given gifts of under $20 to patients or clients (81.0%). The nurses specializing in child and adolescent mental health were the least likely to report that they had never given gifts of under $20 to patients or clients (45.2%).

There was a significant difference, as shown in the ANOVA, in the respondents' gift-giving behaviours of lending money to patients or clients, accepting gifts of under $20 from patients or clients, and giving gifts of under $20 to patient or clients based on the specialty area of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar gift-giving behaviours was rejected. Table 16 outlines the comparison of the gift-giving behaviours reported by the respondents based on their specialty area.

Table 16

Analysis of Variance for Gift-Giving Behaviours by Specialty Area

Source	df	F Specialty Area	Sig.
Lent Money To Patients			
Between groups	6	2.858	0.009*
Within groups	871		
Borrowed Money From Patients			
Between groups	6	0.357	0.906
Within groups	873		
Accepted Gifts Under $20			
Between groups	6	5.742	0.000*
Within groups	872		
Accepted Gifts Over $20			
Between groups	6	1.803	0.096
Within groups	870		
Given Gifts Under $20			
Between groups	6	4.526	0.000*
Within groups	872		
Given Gifts Over $20			
Between groups	6	0.768	0.595
Within groups	872		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the respondents' *current work area* and their gift-giving behaviours. The cross tabulation results are similar to those obtained when the data were examined for specialty area. Respondents currently working in the area of forensic nursing were the most likely (81.6%) to report that they had never lent money to patients or clients. Nurses currently working in adult mental health nursing were the least likely (50.0%) to report that they had never lent money to patients or clients. Similar to the results obtained when comparing gift-giving attitudes, the nurses currently working in forensic mental health nursing were the most likely (61.2%) to report that they had never accepted gifts of under $20 from patients or clients. Nurses currently working in child and adolescent mental health were the least likely (28.0%) to report that they had never done so. When asked about their practices in giving gifts of under $20, the nurses currently working in forensic mental health (81.6%) and group therapy (79.4%) were again the most likely to report that they had never given gifts of under $20. The nurses working in child and adolescent mental health reported that they were the least likely to have done so (46.7%).

There was a significant difference, as shown in the ANOVA, in the respondents' gift-giving behaviours of lending money to patients or clients, accepting gifts of under $20 from patients or clients, and giving gifts of under $20 to patient or clients based on the current work area of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar gift-giving behaviours was rejected. Table 17 outlines the comparison of the gift-giving behaviours reported by the respondents based on their current work area.

Table 17

Analysis of Variance for Gift-Giving Behaviours by Current Work Area

Source	df	F Current Work Area	Sig.
Lent Money To Patients			
Between groups	6	5.511	0.000*
Within groups	888		
Borrowed Money From Patients			
Between groups	6	0.753	0.607
Within groups	890		
Accepted Gifts Under $20			
Between groups	6	5.238	0.000*
Within groups	888		
Accepted Gifts Over $20			
Between groups	6	1.970	0.067
Within groups	887		
Given Gifts Under $20			
Between groups	6	4.191	0.000*
Within groups	889		
Given Gifts Over $20			
Between groups	6	0.588	0.740
Within groups	889		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the respondents' *workplace location* and their gift-giving behaviours. The ANOVA showed that there was a significant difference in the respondents' gift-giving behaviours of lending money to patients or clients and giving gifts of under $20 to patients or clients based on the workplace location of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar gift-giving behaviours was rejected. Table 18 outlines the comparison of the gift-giving behaviours reported by the respondents based on workplace location.

Table 18

Analysis of Variance for Gift-Giving Behaviours by Workplace Location

Source	df	F Workplace Location	Sig.
Lent Money To Patients			
Between groups	4	2.676	0.031*
Within groups	868		
Borrowed Money From Patients			
Between groups	4	0.214	0.931
Within groups	870		
Accepted Gifts Under $20			
Between groups	4	2.206	0.067
Within groups	868		
Accepted Gifts Over $20			
Between groups	4	0.641	0.633
Within groups	867		
Given Gifts Under $20			
Between groups	4	4.186	0.002*
Within groups	869		
Given Gifts Over $20			
Between groups	4	1.603	0.172
Within groups	869		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their gift-giving behaviours. There was a significant difference, as shown in the ANOVA, in the respondents' gift-giving behaviours of lending money to patients or clients, giving gifts of under $20 to patients or clients, and giving gifts of over $20 to patient or clients based on the amount of time worked by the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar gift-giving behaviours was rejected. Table 19 outlines the comparison of the gift-giving behaviours reported by the respondents based on the amount of time worked.

Table 19

Analysis of Variance for Gift Giving Behaviours by Amount of Time Worked

		F	
Source	**df**	**Amt. of Time Worked**	**Sig.**
Lent Money To Patients			
Between groups	2	3.687	0.025*
Within groups	880		
Borrowed Money From Patients			
Between groups	2	0.934	0.393
Within groups	882		
Accepted Gifts Under $20			
Between groups	2	0.642	0.527
Within groups	880		
Accepted Gifts Over $20			
Between groups	2	0.715	0.489
Within groups	879		

(table continues)

Source	df	F Amt. of Time Worked	Sig.
Given Gifts Under $20			
Between groups	2	4.328	0.013*
Within groups	881		
Given Gifts Over $20			
Between groups	2	3.079	0.047*
Within groups	881		

Note. *$p < 0.05$.

In summary, in an examination of the attitudes toward gift giving, the null hypotheses that all mental health nurses, regardless of marital status and amount of time worked have similar gift-giving attitudes were accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) gender, (c) nursing education, (d) years of experience, (e) specialty area, (f) current work area, and (g) workplace location, have similar gift-giving attitudes were rejected. As well, when investigating gift-giving behaviours, the null hypotheses that all mental health nurses, regardless of age and marital status, have similar gift-giving behaviours were accepted. The null hypotheses that all mental health nurses, regardless of (a) gender, (b) nursing education, (c) years of experience, (d) specialty area, (e) current work area, (f) workplace location, and (g) amount of time worked, have similar gift-giving behaviours were rejected.

Personal Disclosure

To determine the respondents' values around personal disclosure when providing care to patients or clients, the survey participants were asked to describe their attitudes about (a) using first names, (b) discussing their religious beliefs, (c) discussing their own interpersonal issues, (d) discussing their own mental health issues, (e) cursing or swearing during interactions, (f) providing their home phone number, and (g) providing their home address. The participants were also asked to indicate their own behaviours with patients and clients regarding personal disclosure including how often they had (a) used first names, (b) discussed their religious beliefs, (c) discussed their own interpersonal issues, (d) discussed their own mental health issues, (e) cursed or sworn during interactions, (f) provided their home phone number, (g) provided their home address. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) area of specialty, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables pertaining to the attitudes and behaviours of personal disclosure were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

Attitudes Toward Personal Disclosure

The majority of the respondents in this survey (72.6%) felt strongly that it was appropriate to use first names, but only 3.5% felt strongly that it was appropriate to discuss religious beliefs with their patients or clients. Most of the nurses surveyed also believed strongly that it was not appropriate to discuss their own interpersonal issues (65.9%) or mental health issues (79.1%) with patients or clients. Cursing or swearing when interacting with mental health patients or clients was strongly believed to be inappropriate by 72.5% of the respondents. The respondents also believed strongly that it was inappropriate to provide their home phone number (88.1%) or home address (94.6%) to a mental health client or patient. Table 20 outlines the respondents' attitudes toward personal disclosure.

Table 20

Attitudes Toward Personal Disclosure

Rating of Frequency	Frequency	Percentage
OK to Use First Names		
Strongly disagree	12	1.3
Disagree somewhat	5	0.5
Neutral	45	4.9
Agree somewhat	184	19.9
Strongly agree	670	72.6
No response	7	0.8
OK to Discuss Religious Beliefs		
Strongly disagree	323	35.0
Disagree somewhat	283	30.7
Neutral	232	25.1
Agree somewhat	49	5.3
Strongly agree	32	3.5
No response	4	0.4

(table continues)

Rating of Frequency	Frequency	Percentage
OK to Discuss Own Interpersonal Issues		
Strongly disagree	608	65.9
Disagree somewhat	210	22.8
Neutral	80	8.7
Agree somewhat	12	1.3
Strongly agree	7	0.8
No response	6	0.7
OK to Discuss Own Mental Health Issues		
Strongly disagree	730	79.1
Disagree somewhat	130	14.1
Neutral	48	5.2
Agree somewhat	5	0.5
Strongly agree	4	0.4
No response	6	0.7
OK to Curse or Swear During Interactions		
Strongly disagree	669	72.5
Disagree somewhat	166	18.0
Neutral	69	7.5
Agree somewhat	9	1.0
Strongly agree	5	0.5
No response	5	0.5
OK to Provide Home Phone Number		
Strongly disagree	813	88.1
Disagree somewhat	65	7.0
Neutral	25	2.7
Agree somewhat	8	0.9
Strongly agree	7	0.8
No response	5	0.5
OK to Provide Home Address		
Strongly disagree	873	94.6
Disagree somewhat	27	2.9
Neutral	8	0.9
Agree somewhat	5	0.5
Strongly agree	6	0.7
No Response	4	0.4

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were then examined to determine if there was a significant relationship between the *age* of the respondents and their attitudes toward personal disclosure. The cross tabulations indicated that the younger a participant was, the more likely he or she would strongly agree that it was appropriate, when interacting with patients or clients, to use first names, discuss their own interpersonal issues, and discuss their own mental health issues. As well, the older the participant was, the more likely he or she would strongly disagree that it was appropriate to discuss religious beliefs with patients or clients. Nurses aged 61 to 70 were the most likely to strongly disagree (85.2%) that it was appropriate to curse or swear during interactions with patients or clients. The participants who were the least likely to strongly disagree that it was appropriate to curse or swear during interactions with patients or clients were those nurses in the 31 to 40 age group (62.5%) and in the 21 to 30 age group (65.4%).

There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents, when interacting with patients or clients, of the appropriateness of using first names, discussing religious beliefs, discussing own interpersonal issues, discussing own mental health issues, and cursing or swearing, based on their age. Therefore, the null hypothesis that the respondents, regardless of age, have similar attitudes toward personal disclosure was rejected. Table 21 illustrates the comparison of the attitudes toward personal disclosure reported by the respondents based on age.

Table 21

Analysis of Variance for Attitudes Toward Personal Disclosure by Age

Source	df	F Age	Sig.
OK to Use First Names with Patients			
Between groups	4	4.235	0.002*
Within groups	892		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	4	4.364	0.002*
Within groups	895		
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	4	5.254	0.000*
Within groups	893		
OK to Discuss Own Mental Health Issues with Patients			
Between groups	4	3.160	0.014*
Within groups	893		
OK to Curse or Swear When Interacting with Patients			
Between groups	4	5.975	0.000*
Within groups	894		
OK to Provide Home Phone Number to Patients			
Between groups	4	1.086	0.362
Within groups	894		
OK to Provide Home Address to Patients			
Between groups	4	1.017	0.397
Within groups	895		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *gender* of the respondents and their attitudes toward personal disclosure. There was a significant difference in the ANOVA results in the attitudes of the respondents, when interacting with patients or clients, of the appropriateness of discussing their own mental health issues, cursing or swearing, and providing their home phone number, based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar attitudes toward personal disclosure was rejected. Table 22 illustrates the comparison of the attitudes toward personal disclosure reported by the respondents based on gender.

Table 22

Analysis of Variance for Attitudes Toward Personal Disclosure by Gender

		F	
Source	**df**	**Gender**	**Sig.**
OK to Use First Names with Patients			
Between groups	1	0.631	0.427
Within groups	907		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	1	1.612	0.205
Within groups	910		
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	1	1.401	0.237
Within groups	908		
OK to Discuss Own Mental Health Issues with Patients			
Between groups	1	5.247	0.022*
Within groups	908		

(table continues)

Source	df	F Gender	Sig.
OK to Curse or Swear When Interacting with Patients			
Between groups	1	8.245	0.004*
Within groups	909		
OK to Provide Home Phone Number to Patients			
Between groups	1	5.000	0.026*
Within groups	909		
OK to Provide Home Address to Patients			
Between groups	1	0.853	0.356
Within groups	910		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status* of the respondents and their attitudes toward gift giving. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar attitudes toward personal disclosure was accepted.

The data were then examined to determine if there was a significant relationship between the *nursing education* of the respondents and their attitudes toward personal disclosure. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents, when interacting with patients or clients, of the appropriateness of discussing religious beliefs, cursing or swearing, providing their home phone number, and proving their home address, based on nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar attitudes toward personal disclosure was rejected. Table 23 illustrates the comparison of the respondents' attitudes toward personal disclosure based on nursing education.

Table 23

Analysis of Variance for Attitudes Toward Personal Disclosure by Nursing Education

		F	
Source	**df**	**Nursing Education**	**Sig.**
OK to Use First Names with Patients			
Between groups	5	1.572	0.165
Within groups	904		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	5	3.008	0.011*
Within groups	907		
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	5	1.272	0.274
Within groups	905		
OK to Discuss Own Mental Health Issues with Patients			
Between groups	5	1.041	0.392
Within groups	905		
OK to Curse or Swear When Interacting with Patients			
Between groups	5	2.706	0.019*
Within groups	906		
OK to Provide Home Phone Number to Patients			
Between groups	5	4.913	0.000*
Within groups	906		
OK to Provide Home Address to Patients			
Between groups	5	4.594	0.000*
Within groups	907		

Note. $^{*}p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *years of experience* of the respondents and their attitudes toward personal disclosure. The cross tabulations indicated that the less experienced that a nurse was, the more likely he or she was to state that he or she strongly agreed that it was appropriate to use first names when interacting with patients or clients. There was, as well, a significant difference in the ANOVA results in the attitudes of the respondents, when interacting with patients or clients, regarding the appropriateness of using first names and discussing religious beliefs based on years of experience. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar attitudes toward personal disclosure was rejected. Table 24 illustrates the comparison of the attitudes toward personal disclosure reported by the respondents based on years of experience.

Table 24

Analysis of Variance for Attitudes Toward Personal Disclosure by Years of Experience

		F	
Source	**df**	**Years of Experience**	**Sig.**
OK to Use First Names with Patients			
Between groups	4	2.598	0.035*
Within groups	887		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	4	2.406	0.048*
Within groups	890		

(table continues)

Source	df	F Years of Experience	Sig.
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	4	1.590	0.175
Within groups	888		
OK to Discuss Own Mental Health Issues with Patients			
Between groups	4	0.640	0.634
Within groups	889		
OK to Curse or Swear When Interacting with Patients			
Between groups	4	2.173	0.070
Within groups	889		
OK to Provide Home Phone Number to Patients			
Between groups	4	0.520	0.721
Within groups	889		
OK to Provide Home Address to Patients			
Between groups	4	1.555	0.184
Within groups	890		

Note. $^*p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *specialty area* of the respondents and their attitudes toward personal disclosure. The cross tabulations indicated that the respondents specializing in child and adolescent mental health were the most likely (83.8%) to report that they strongly agreed that it was appropriate to use first names with patients or clients, whereas participants specializing in geriatric nursing (61.5%) and those with no specialty area (61.5%) were the least likely. The participants specializing in geriatric nursing were also the most likely (85.3%) to strongly disagree that it was appropriate to curse or swear when interacting with patients or clients, whereas the nurses specializing in group therapy were the least likely (47.5%). Nurses in the specialty area of geriatrics were, again, the most likely to strongly or somewhat agree that it was appropriate to discuss their own religious beliefs with patients or clients (19.9%), whereas nurses specializing in group therapy were the least likely (5.0%).

There was, as well, a significant difference in the ANOVA results in the attitudes of the respondents, when interacting with patients or clients, of the appropriateness of using first names, discussing religious beliefs, and cursing or swearing based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar attitudes toward personal disclosure was rejected. Table 25 illustrates the comparison of the attitudes toward personal disclosure reported by the respondents based on specialty area.

Table 25

Analysis of Variance for Attitudes Toward Personal Disclosure by Specialty Area

		F	
Source	**df**	**Specialty Area**	**Sig.**
OK to Use First Names with Patients			
Between groups	6	2.608	0.016*
Within groups	873		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	6	3.676	0.001**
Within groups	876		
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	6	1.030	0.404
Within groups	874		

(table continues)

		F	
Source	df	Specialty Area	Sig.
OK to Discuss Own Mental Health Issues with Patients			
Between groups	6	1.211	0.298
Within groups	875		
OK to Curse or Swear When Interacting with Patients			
Between groups	6	4.015	0.001*
Within groups	875		
OK to Provide Home Phone Number to Patients			
Between groups	6	0.949	0.459
Within groups	875		
OK to Provide Home Address to Patients			
Between groups	6	1.167	0.321
Within groups	876		

Note. $^{*}p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *current work area* of the respondents and their attitudes toward personal disclosure. The cross tabulations results were similar to those obtained for the variable of specialty area, with geriatric nurses the least likely to report that they strongly agreed that it was appropriate to use first names with patients or clients (62.1%) and the most likely to disagree that it was appropriate to curse and swear when interacting with patients or clients (83.7%). The nurses working in child and adolescent mental health were the most likely to report that they strongly agreed that it was appropriate to use first names with patients or clients (81.6%); and the participants working in group therapy were, again, the least likely to strongly disagree that it was appropriate to curse or swear when interacting with patients or clients (58.8%). The participants working in forensic nursing were the most likely to report that they strongly disagreed that it was appropriate to provide their home phone number to a patient or client (95.9%).

There was, as well, a significant difference, as shown in the ANOVA, in the attitudes of the respondents, when interacting with patients or clients, of the appropriateness of using first names, discussing religious beliefs, cursing or swearing, and providing their home phone number, based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar attitudes toward personal disclosure was rejected. Table 26 illustrates the comparison of the attitudes toward personal disclosure reported by the respondents based on current work area.

Table 26

Analysis of Variance for Attitudes Toward Personal Disclosure by Current Work Area

		F	
Source	**df**	**Current Work Area**	**Sig.**
OK to Use First Names with Patients			
Between groups	6	2.209	0.040*
Within groups	890		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	6	2.161	0.045*
Within groups	893		
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	6	1.346	0.234
Within groups	891		

(table continues)

Source	df	F Current Work Area	Sig.
OK to Discuss Own Mental Health Issues with Patients			
Between groups	6	1.204	0.302
Within groups	891		
OK to Curse or Swear When Interacting with Patients			
Between groups	6	2.913	0.008*
Within groups	892		
OK to Provide Home Phone Number to Patients			
Between groups	6	2.261	0.036*
Within groups	892		
OK to Provide Home Address to Patients			
Between groups	6	0.431	0.859
Within groups	893		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *workplace location* of the respondents and their attitudes toward personal disclosure. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents, when interacting with patients or clients, of the appropriateness of providing their home phone number and providing their home phone address based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar attitudes toward personal disclosure was rejected. Table 27 illustrates the comparison of the attitudes toward personal disclosure reported by the respondents based on workplace location.

Table 27

Analysis of Variance for Attitudes Toward Personal Disclosure by Workplace Location

Source	df	F Workplace Location	Sig.
OK to Use First Names with Patients			
Between groups	4	0.907	0.459
Within groups	871		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	4	0.559	0.693
Within groups	874		
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	4	1.017	0.397
Within groups	872		
OK to Discuss Own Mental Health Issues with Patients			
Between groups	4	1.632	0.164
Within groups	872		
OK to Curse or Swear When Interacting with Patients			
Between groups	4	0.308	0.873
Within groups	873		
OK to Provide Home Phone Number to Patients			
Between groups	4	10.061	0.000*
Within groups	873		
OK to Provide Home Address to Patients			
Between groups	4	5.302	0.000*
Within groups	874		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their attitudes toward personal disclosure. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents, when interacting with patients or clients, of the appropriateness of discussing their religious beliefs and providing their home phone number based on the amount of time worked. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar attitudes toward personal disclosure was rejected. Table 28 illustrates the comparison of the attitudes toward personal disclosure reported by the respondents based on the amount of time worked.

Table 28

Analysis of Variance for Attitudes Toward Personal Disclosure by Amount of Time Worked

Source	df	F Amt. of Time Worked	Sig.
OK to Use First Names with Patients			
Between groups	2	0.423	0.655
Within groups	883		
OK to Discuss Own Religious Beliefs with Patients			
Between groups	2	6.343	0.002*
Within groups	886		
OK to Discuss Own Interpersonal Issues with Patients			
Between groups	2	0.810	0.445
Within groups	884		

(table continues)

Source	df	F Amt. of Time Worked	Sig.
OK to Discuss Own Mental Health Issues with Patients			
Between groups	2	1.004	0.367
Within groups	884		
OK to Curse or Swear When Interacting with Patients			
Between groups	2	1.068	0.344
Within groups	885		
OK to Provide Home Phone Number to Patients			
Between groups	2	3.140	0.044*
Within groups	885		
OK to Provide Home Address to Patients			
Between groups	2	0.378	0.686
Within groups	886		

Note. $^*p < 0.05$.

Behaviours and Personal Disclosure

Almost 50% of the respondents in this survey reported that they always used first names with patients or clients; and, conversely, less than one percent stated that they never used first names. The respondents also related that they had never (43.3%) or rarely (39.8%) discussed religious beliefs with patients or clients. As well, a preponderance of nurses had never discussed their own interpersonal issues (64.8%) or mental health issues (85.0%) with a patient or client. Additionally, 64.2% of the respondents replied that they had never cursed or sworn during patient and client interactions. The vast majority reported that they had never provided their home phone number (88.5%) or home address

(95.9%) to a patient or client. Table 29 outlines the respondents' behaviours around personal disclosure.

Table 29

Behaviours Around Personal Disclosure

Rating of Frequency	Frequency	Percentage
Used First Names with Patients		
Never	8	0.9
Rarely	9	1.0
Sometimes	56	6.1
Often	389	42.1
Always	454	49.2
No response	7	0.8
Discussed Religious Beliefs with Patients		
Never	400	43.3
Rarely	367	39.8
Sometimes	142	15.4
Often	7	0.8
Always	2	0.2
No response	5	0.5
Discussed Own Interpersonal Issues with Patients		
Never	598	64.8
Rarely	273	29.6
Sometimes	43	4.7
Often	0	0
Always	1	0.1
No response	8	0.9
Discussed Own Mental Health Issues with Patients		
Never	785	85.0
Rarely	113	12.2
Sometimes	18	2.0
Often	1	0.1
Always	1	0.1
No response	5	0.5

(table continues)

Rating of Frequency	Frequency	Percentage
Cursed or Swore During Interactions with Patients		
Never	593	64.2
Rarely	241	26.1
Sometimes	77	8.3
Often	4	0.4
Always	1	0.1
No response	7	0.8
Provided Home Phone Number to Patients		
Never	817	88.5
Rarely	80	8.7
Sometimes	16	1.7
Often	4	0.4
Always	1	0.1
No response	5	0.5
Provided Home Address to Patients		
Never	885	95.9
Rarely	27	2.9
Sometimes	5	0.5
Often	0	0
Always	1	0.1
No response	5	0.5

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were then examined to determine if there was a significant relationship between the *ages* of the respondents and their behaviours around personal disclosure. Nurses in the youngest age group (21 to 30) were the most likely to report that they always used first names with patients or clients (63.5%). The cross tabulation results indicated that the nurses in the 61 to 70 age group were the most likely to report that they had never cursed or sworn when interacting with patients or clients (80.8%). Younger nurses were the least likely to report that they had never cursed or sworn when interacting with patients or to report that they had never cursed or sworn when interacting with patients or clients (54.9% in the 21 to 30 age group and 53.0% in the 31 to 40 age group). There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in using first names, cursing or swearing, and providing their home phone number based on age. Therefore, the null hypothesis that the respondents, regardless of age, have similar behaviours around personal disclosure was rejected. Table 30 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on age.

Table 30

Analysis of Variance for Behaviours Around Personal Disclosure by Age

		F	
Source	**df**	**Age**	**Sig.**
Used First Names with Patients			
Between groups	4	3.992	0.003*
Within groups	892		
Discussed Own Religious Beliefs with Patients			
Between groups	4	1.687	0.151
Within groups	894		
Discussed Own Interpersonal Issues with Patients			
Between groups	4	1.434	0.221
Within groups	891		
Discussed Own Mental Health Issues with Patients			
Between groups	4	0.721	0.578
Within groups	894		

(table continues)

Source	df	F Age	Sig.
Cursed or Swore When Interacting with Patients			
Between groups	4	6.425	0.000*
Within groups	892		
Provide Home Phone Number to Patients			
Between groups	4	3.920	0.004*
Within groups	894		
Provided Home Address to Patients			
Between groups	4	1.557	0.184
Within groups	894		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *gender* of the respondents and their behaviours around personal disclosure. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in discussing religious beliefs and cursing or swearing based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar behaviours around personal disclosure was rejected. Table 31 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on gender.

Table 31

Analysis of Variance for Behaviours Around Personal Disclosure by Gender

		F	
Source	**df**	**Gender**	**Sig.**
Used First Names with Patients			
Between groups	1	0.038	0.846
Within groups	907		
Discussed Own Religious Beliefs with Patients			
Between groups	1	4.622	0.032*
Within groups	909		
Discussed Own Interpersonal Issues with Patients			
Between groups	1	2.654	0.104
Within groups	906		
Discussed Own Mental Health Issues with Patients			
Between groups	1	3.419	0.065
Within groups	909		
Cursed or Swore When Interacting with Patients			
Between groups	1	5.587	0.018*
Within groups	907		
Provide Home Phone Number to Patients			
Between groups	1	1.335	0.248
Within groups	909		
Provided Home Address to Patients			
Between groups	1	0.248	0.619
Within groups	909		

Note. $^{*}p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status* of the respondents and their behaviours around gift giving. No significant relationship was found in the ANOVA.

Therefore, the null hypothesis that the respondents, regardless of marital status, have similar behaviours around personal disclosure was accepted.

The data were then examined to determine if there was a significant relationship between the *nursing education* of the respondents and their behaviours around personal disclosure. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in discussing their own interpersonal issues, cursing and swearing, providing their home phone number, and providing their home address based on nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar behaviours around personal disclosure was rejected. Table 32 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on nursing education.

Table 32

Analysis of Variance for Behaviours Around Personal Disclosure by Nursing Education

Source	df	F Nursing Education	Sig.
Used First Names with Patients			
Between groups	5	1.359	0.237
Within groups	904		
Discussed Own Religious Beliefs with Patients			
Between groups	5	1.069	0.376
Within groups	906		

(table continues)

Source	df	F Nursing Education	Sig.
Discussed Own Interpersonal Issues with Patients			
Between groups	5	3.673	0.003*
Within groups	903		
Discussed Own Mental Health Issues with Patients			
Between groups	5	1.112	0.352
Within groups	906		
Cursed or Swore When Interacting with Patients			
Between groups	5	2.973	0.011*
Within groups	904		
Provide Home Phone Number to Patients			
Between groups	5	3.825	0.002*
Within groups	906		
Provided Home Address to Patients			
Between groups	5	3.137	0.008*
Within groups	906		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *years of experience* of the respondents and their behaviours around personal disclosure. As indicated by the cross tabulation, nurses with the most experience (41 to 50) years of experience were the least likely to report that they always used first names when interacting with patients or clients (25.0%), whereas nurses with 11 to 20 years experience (51.7%) and 0 to 10 years of experience (49.8%) were the most likely. Similarly, nurses with 11 to 20 years of experience were the least likely to report that they had never cursed or sworn (57.4%) when interacting with patients or clients, and nurses with 41 to

50 years were the most likely to report that they had never cursed or sworn (100%). There was also a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in cursing or swearing based on years of experience. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar behaviours around personal disclosure was rejected. Table 33 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on years of experience.

Table 33

Analysis of Variance for Behaviours Around Personal Disclosure by Years of Experience

Source	df	F Years of Experience	Sig.
Used First Names with Patients			
Between groups	4	1.313	0.263
Within groups	887		
Discussed Own Religious Beliefs with Patients			
Between groups	4	0.881	0.474
Within groups	889		
Discussed Own Interpersonal Issues with Patients			
Between groups	4	0.421	0.793
Within groups	887		
Discussed Own Mental Health Issues with Patients			
Between groups	4	0.892	0.468
Within groups	889		

(table continues)

Source	df	F Years of Experience	Sig.
Cursed or Swore When Interacting with Patients			
Between groups	4	2.446	0.045*
Within groups	887		
Provide Home Phone Number to Patients			
Between groups	4	2.298	0.057
Within groups	889		
Provided Home Address to Patients			
Between groups	4	1.797	0.127
Within groups	889		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *specialty area* of the respondents and their behaviours around personal disclosure. As indicated by the cross tabulation, respondents specializing in geriatric nursing were the least likely to report that they always used first names (28.9%), and nurses specializing in forensic nursing (69.0%) and child and adolescent mental health nursing (59.5%) were the most likely. Nurses specializing in geriatric nursing (79.4%) were also the most likely to report that they had never cursed or sworn when interacting with patients or clients. Nurses specializing in forensic nursing (45.2%) and group therapy (45.0%) were the least likely to report that they had never cursed or sworn when interacting with patients or clients. Almost all forensic nurses (97.6%) reported that they had never provided their home phone number to a patient or client.

There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in using first names, cursing or swearing, and proving their home phone number based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar behaviours around personal disclosure was rejected. Table 34 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on specialty area.

Table 34

Analysis of Variance for Behaviours Around Personal Disclosure by Specialty Area

Source	df	*F* Specialty Area	Sig.
Used First Names with Patients			
Between groups	6	8.001	0.000*
Within groups	873		
Discussed Own Religious Beliefs with Patients			
Between groups	6	1.527	0.166
Within groups	875		
Discussed Own Interpersonal Issues with Patients			
Between groups	6	0.591	0.738
Within groups	872		
Discussed Own Mental Health Issues with Patients			
Between groups	6	0.719	0.634
Within groups	875		

(table continues)

Source	df	F Specialty Area	Sig.
Cursed or Swore When Interacting with Patients			
Between groups	6	6.237	0.000*
Within groups	873		
Provide Home Phone Number to Patients			
Between groups	6	3.455	0.002*
Within groups	875		
Provided Home Address to Patients			
Between groups	6	1.182	0.313
Within groups	875		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *current work area* of the respondents and their behaviours around personal disclosure. Similar to the cross tabulation results of the variable specialty area, respondents working in geriatric nursing were the least likely to report that they always used first names (30.0%), and nurses working in forensic nursing (67.3%) and child and adolescent mental health nursing (65.8%) were the most likely. Nurses working in geriatric nursing (76.6%) were also the most likely to report that they had never cursed or sworn when interacting with patients or clients. Nurses working in forensic nursing (51.0%) and group therapy (55.9%) were the least likely to report that they had never cursed or sworn when interacting with patients or clients. Almost all forensic nurses (98.0%) reported that they had never provided their home phone number to a patient or client.

There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in using first names, cursing and swearing, and proving their home phone number based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have behaviours around toward personal disclosure was rejected. Table 35 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on current work area.

Table 35

Analysis of Variance for Behaviours Around Personal Disclosure by Current Work Area

Source	df	F Current Work Area	Sig.
Used First Names with Patients			
Between groups	6	6.502	0.000*
Within groups	890		
Discussed Own Religious Beliefs with Patients			
Between groups	6	1.068	0.380
Within groups	892		
Discussed Own Interpersonal Issues with Patients			
Between groups	6	1.408	0.208
Within groups	889		
Discussed Own Mental Health Issues with Patients			
Between groups	6	0.870	0.516
Within groups	892		

(table continues)

		F	
Source	**df**	**Current Work Area**	**Sig.**
Cursed or Swore When Interacting with Patients			
Between groups	6	3.347	0.003*
Within groups	890		
Provide Home Phone Number to Patients			
Between groups	6	3.152	0.005*
Within groups	892		
Provided Home Address to Patients			
Between groups	6	0.774	0.590
Within groups	892		

Note. $^{*}p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *workplace location* of the respondents and their behaviours around personal disclosure. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in providing their home phone number and providing their home address based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar behaviours around personal disclosure was rejected. Table 36 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on workplace location.

Table 36

Analysis of Variance for Behaviours Around Personal Disclosure by Workplace Location

Source	df	F Workplace Location	Sig.
Used First Names with Patients			
Between groups	4	1.101	0.355
Within groups	871		
Discussed Own Religious Beliefs with Patients			
Between groups	4	0.654	0.624
Within groups	873		
Discussed Own Interpersonal Issues with Patients			
Between groups	4	1.375	0.241
Within groups	871		
Discussed Own Mental Health Issues with Patients			
Between groups	4	2.064	0.084
Within groups	873		
Cursed or Swore When Interacting with Patients			
Between groups	4	1.070	0.370
Within groups	871		
Provide Home Phone Number to Patients			
Between groups	4	7.638	0.000*
Within groups	873		
Provided Home Address to Patients			
Between groups	4	3.748	0.005*
Within groups	873		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their behaviours around personal disclosure. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents, when interacting with patients or clients, in discussing their religious beliefs and providing their home phone number based on the amount of time worked. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar behaviours around personal disclosure was rejected. Table 37 illustrates the comparison of the behaviours around personal disclosure reported by the respondents based on the amount of time worked.

Table 37

Analysis of Variance for Behaviours Around Personal Disclosure by Amount of Time Worked

		F	
Source	**df**	**Amt. of Time Worked**	**Sig.**
Used First Names with Patients			
Between groups	2	0.186	0.830
Within groups	883		
Discussed Own Religious Beliefs with Patients			
Between groups	2	3.074	0.047*
Within groups	885		
Discussed Own Interpersonal Issues with Patients			
Between groups	2	0.420	0.657
Within groups	882		

(table continues)

Source	df	F Amt. of Time Worked	Sig.
Discussed Own Mental Health Issues with Patients			
Between groups	2	0.649	0.523
Within groups	885		
Cursed or Swore When Interacting with Patients			
Between groups	2	2.107	0.122
Within groups	883		
Provide Home Phone Number to Patients			
Between groups	2	3.516	0.030*
Within groups	885		
Provided Home Address to Patients			
Between groups	2	1.252	0.286
Within groups	885		

Note. *$p < 0.05$.

In summary, in an examination of the respondents' attitudes toward personal disclosure, the null hypothesis that all mental health nurses, regardless of marital status, have similar gift giving attitudes was accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) gender, (c) nursing education, (d) years of experience, (e) specialty area, (f) current work area, (g) workplace location, and (h) amount of time worked, have similar attitudes toward personal disclosure were rejected. As well, the null hypothesis that all mental health nurses, regardless of marital status, have similar behaviours around personal disclosure was accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) gender, (c) nursing education, (d) years of experience, (e) specialty area, (f) current work area, (g) workplace location, and (h) amount of time worked, have similar behaviours toward personal disclosure were rejected.

Confidentiality and Secrecy

To determine the respondents' attitudes toward keeping confidences and secrecy, the survey participants were asked if it was appropriate to (a) ask a patient or client to keep a confidence from the treatment team, (b) keep a confidence regarding others in the patient's or client's life from the treatment team at the request of a patient or client, (c) keep a confidence regarding the patient or client from the treatment team at the request of a patient or client, (d) keep a confidence regarding the safety of a patient or client from the treatment team at the request of a patient or client, and (e) keep a confidence regarding the safety of others in the patient's or clients life from the treatment team at the request of a patient or client.

The respondents were also asked to relate their own behaviours with patients and clients regarding secrecy and confidentiality by indicating how often they had (a) asked a patient or client to keep a confidence from the treatment team, (b) kept a confidence regarding others in the patient's or client's life from the treatment team at the request of a patient or client, (c) kept a confidence regarding the patient or client from the treatment team at the request of a patient or client, (d) kept a confidence regarding the safety of a patient or client from the treatment team at the request of a patient or client, and (e) kept a confidence regarding the safety of others in the patient's or clients life from the treatment team at the request of a patient or client. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables concerning the attitudes and behaviours of confidentiality and secrecy were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

Attitudes Toward Confidentiality and Secrecy

The vast majority of the respondents in this survey (90.0%) felt strongly that it was not appropriate to ask a patient or client to keep a confidence from the treatment team. As well, 92.7% of the participants felt strongly that it was not appropriate to keep a confidence regarding the safety of the patient or client from the treatment team at the request of the patient or client. Moreover, 89.6% felt strongly that it was not appropriate to keep a confidence regarding the safety of others in the patient or client's life from the treatment team at the request of the patient or client. However, only 53.3% of those surveyed felt strongly that it was not appropriate to keep a confidence regarding others in the patient or client's life from the treatment team at the request of a patient or client. Furthermore, only 61.1% felt strongly that it was not appropriate to keep a confidence regarding the patient or client from the treatment team at the request of a patient or client. Table 38 indicates the respondents' attitudes toward confidentiality and keeping secrets.

Table 38

Attitudes Toward Secrecy and Keeping Confidences

Rating of Frequency	Frequency	Percentage
OK to Ask a Patient to Keep a Confidence From the Treatment Team		
Strongly disagree	831	90.0
Disagree somewhat	54	5.9
Neutral	13	1.4
Agree somewhat	3	0.3
Strongly agree	5	0.5
No response	17	1.8
OK to Keep a Patient Confidence Regarding Others in Patient's Life		
Strongly disagree	492	53.3
Disagree somewhat	182	19.7
Neutral	142	15.4
Agree somewhat	53	5.7
Strongly agree	29	3.1
No response	25	2.7
OK to Keep a Patient Confidence From the Treatment Team		
Strongly disagree	564	61.1
Disagree somewhat	187	20.3
Neutral	107	11.6
Agree somewhat	33	3.6
Strongly agree	14	1.5
No response	18	2.0
OK to Keep a Patient Confidence Regarding Patient's Safety		
Strongly disagree	856	92.7
Disagree somewhat	30	3.3
Neutral	9	1.0
Agree somewhat	5	0.5
Strongly agree	6	0.7
No response	17	1.8
OK to Keep a Patient Confidence Regarding Other's Safety		
Strongly disagree	827	89.6
Disagree somewhat	52	5.6
Neutral	19	2.1
Agree somewhat	5	0.5
Strongly agree	6	0.7
No response	14	1.5

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were then examined to determine if there was a significant relationship between the *age* of the respondents and their attitudes toward confidentiality and secrecy when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in attitudes of the respondents regarding the appropriateness of asking a patient or client to keep a confidence from the treatment team based on age. Therefore, the null hypothesis that the respondents, regardless of age, have similar attitudes toward confidentiality and secrecy was rejected. Table 39 illustrates the comparison of the attitudes toward confidentiality and secrecy reported by the respondents based on age.

Table 39

Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Age

		F	
Source	**df**	**Age**	**Sig.**
OK to Ask a Patient to Keep a Confidence From the Treatment Team			
Between groups	4	5.320	0.000*
Within groups	882		
OK to Keep a Patient Confidence Regarding Others in Patient's Life			
Between groups	4	0.053	0.995
Within groups	876		
OK to Keep a Patient Confidence From the Treatment Team			
Between groups	4	0.802	0.524
Within groups	882		
OK to Keep a Patient Confidence Regarding Patient's Safety			
Between groups	4	2.008	0.091
Within groups	883		
OK to Keep a Patient Confidence Regarding Other's Safety			
Between groups	4	0.902	0.462
Within groups	886		

Note. * $p < 0.05$.

The data were examined to determine if there was a significant relationship between the *gender* of the respondents and their attitudes toward confidentiality and secrecy when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of asking a patient or client to keep a confidence from the treatment team and keeping a confidence regarding the safety of others in the patient or client's life from the treatment team at the request of the patient or client based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar attitudes toward confidentiality and secrecy was rejected. Table 40 illustrates the comparison of the attitudes toward confidentiality and secrecy reported by the respondents based on gender.

Table 40

Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Gender

Source	df	F Gender	Sig.
OK to Ask a Patient to Keep a Confidence From the Treatment Team			
Between groups	1	4.410	0.036*
Within groups	897		
OK to Keep a Patient Confidence Regarding Others in Patient's Life			
Between groups	1	0.050	0.823
Within groups	890		
OK to Keep a Patient Confidence From the Treatment Team			
Between groups	1	0.322	0.571
Within groups	896		

(table continues)

Source	df	F Gender	Sig.
OK to Keep a Patient Confidence Regarding Patient's Safety			
Between groups	1	6.733	0.010*
Within groups	897		
OK to Keep a Patient Confidence Regarding Other's Safety			
Between groups	1	2.758	0.097
Within groups	900		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status* of the respondents and their attitudes toward confidentiality and secrecy. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar attitudes toward confidentiality and secrecy was accepted.

The data were examined to determine if there was a significant relationship between the *nursing education* of the respondents and their attitudes toward confidentiality and secrecy when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in attitudes of the respondents regarding the appropriateness of keeping a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client based on nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar attitudes toward confidentiality and secrecy was rejected. Table 41 illustrates the comparison of the attitudes toward confidentiality and secrecy reported by the respondents based on nursing education.

Table 41

Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Nursing Education

Source	df	F Nursing Education	Sig.
OK to Ask a Patient to Keep a Confidence From the Treatment Team			
Between groups	5	1.528	0.179
Within groups	894		
OK to Keep a Patient Confidence Regarding Others in Patient's Life			
Between groups	5	2.393	0.036*
Within groups	886		
OK to Keep a Patient Confidence From the Treatment Team			
Between groups	5	0.305	0.910
Within groups	893		
OK to Keep a Patient Confidence Regarding Patient's Safety			
Between groups	5	0.308	0.908
Within groups	894		
OK to Keep a Patient Confidence Regarding Other's Safety			
Between groups	5	0.336	0.891
Within groups	897		

Note. $^{*}p < 0.05$.

The data were examined to determine if there was a significant relationship between the *years of experience* of the respondents and their attitudes toward confidentiality and secrecy. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar attitudes toward confidentiality and secrecy was accepted.

The data were examined to determine if there was a significant relationship between the *specialty area* of the respondents and their attitudes toward confidentiality and secrecy when interacting with patients and clients. The cross tabulation results indicated that the participants specializing in group therapy were the most likely to strongly disagree that it was appropriate to keep a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client (69.2%), whereas those who reported that they had no specialty area were the least likely (40.0%) to strongly disagree. The participants specializing in forensic nursing were the most likely to strongly disagree that it was appropriate to keep a confidence regarding the patient or client from the treatment team at the request of the patient or client (73.8%), whereas those specializing in child and adolescent nursing were the least likely (50.7%) to strongly disagree.

Again, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of asking a patient or client to keep a confidence from the treatment team, keeping a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client, and keeping a confidence regarding the patient or client from the treatment team at the request of the patient or client based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar attitudes toward confidentiality and secrecy was rejected. Table 42 illustrates the comparison of the attitudes toward confidentiality and secrecy reported by the respondents based on specialty area.

Table 42

Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Specialty Area

Source	df	F Specialty Area	Sig.
OK to Ask a Patient to Keep a Confidence From the Treatment Team			
Between groups	6	2.629	0.016*
Within groups	863		
OK to Keep a Patient Confidence Regarding Others in Patient's Life			
Between groups	6	3.542	0.002*
Within groups	858		
OK to Keep a Patient Confidence From the Treatment Team			
Between groups	6	3.507	0.002*
Within groups	864		
OK to Keep a Patient Confidence Regarding Patient's Safety			
Between groups	6	1.136	0.339
Within groups	865		
OK to Keep a Patient Confidence Regarding Other's Safety			
Between groups	6	1.235	0.286
Within groups	867		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *current work area* of the respondents and their attitudes toward confidentiality and secrecy when interacting with patients and clients. The cross tabulation results indicated that the participants currently working in forensic nursing were the most likely to strongly disagree that it was appropriate to keep a confidence regarding the others in the patient or client's life from the treatment team at the request of the patient or client (75.5%%), whereas those who reported that they were not currently working were the least likely (42.9%) to strongly disagree. The participants working in forensic nursing were, again, the most likely to strongly disagree that it was appropriate to keep a confidence regarding the patient or client from the treatment team at the request of the patient or client (79.6%), with those working in other areas of nursing (53.7%) and those working in child and adolescent mental health (53.9%) the least likely to strongly disagree.

There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of asking a patient or client to keep a confidence from the treatment team, keeping a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client, and keeping a confidence regarding the patient or client from the treatment team at the request of the patient or client based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar attitudes toward confidentiality and secrecy was rejected. Table 43 illustrates the comparison of the attitudes toward confidentiality and secrecy reported by the respondents based on current work area.

Table 43

Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Current Work Area

Source	df	F Current Work Area	Sig.
OK to Ask a Patient to Keep a Confidence From the Treatment Team			
Between groups	6	2.179	0.043*
Within groups	881		
OK to Keep a Patient Confidence Regarding Others in Patient's Life			
Between groups	6	4.838	0.000*
Within groups	874		
OK to Keep a Patient Confidence From the Treatment Team			
Between groups	6	5.002	0.000*
Within groups	880		
OK to Keep a Patient Confidence Regarding Patient's Safety			
Between groups	6	1.295	0.257
Within groups	881		
OK to Keep a Patient Confidence Regarding Other's Safety			
Between groups	6	1.563	0.155
Within groups	884		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *workplace location* of the respondents and their attitudes toward confidentiality and secrecy when interacting with patients and clients. The cross tabulation indicated that nurses working in a city of over 500,000 were more likely to strongly disagree that it was appropriate to keep a confidence regarding the patient or client from the treatment team at the request of the patient or client (67.0%) than were those nurses working in a city of under 500,000 (54.9%), a town (54.2%), a village or hamlet, (50.0%), or a rural area (53.8%). There was, as well, a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of keeping a confidence regarding the patient or client from the treatment team at the request of the patient or client based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar attitudes toward confidentiality and secrecy was rejected. Table 44 illustrates the comparison of the respondents' attitudes toward confidentiality and secrecy based on workplace location.

Table 44

Analysis of Variance for Attitudes Toward Confidentiality and Secrecy by Workplace Location

		F	
Source	**df**	**Workplace Location**	**Sig.**
OK to Ask a Patient to Keep a Confidence From the Treatment Team			
Between groups	4	1.131	0.340
Within groups	861		
OK to Keep a Patient Confidence Regarding Others in Patient's Life			
Between groups	4	1.679	0.153
Within groups	853		
OK to Keep a Patient Confidence From the Treatment Team			
Between groups	4	3.573	0.007*
Within groups	860		

(table continues)

		F	
Source	**df**	**Workplace Location**	**Sig.**
OK to Keep a Patient Confidence Regarding Patient's Safety			
Between groups	4	0.325	0.862
Within groups	861		
OK to Keep a Patient Confidence Regarding Other's Safety			
Between groups	4	0.638	0.635
Within groups	864		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their attitudes toward confidentiality and secrecy. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar attitudes toward confidentiality and secrecy was accepted.

Behaviours Around Secrecy and Keeping Confidences

The vast majority of the respondents in this survey (95.6%) reported that they had never requested that a patient keep a confidence from the treatment team. Similarly, 94.4% of the respondents related that they had never kept a confidence regarding the safety of a patient or client from the treatment team at the request of the patient or client. Likewise, 91.8% stated that they had never kept a confidence regarding the safety of others in the patient or client's life from the treatment team at the request of the patient or client. When asked how frequently they would keep a confidence regarding others in the patient or client's life, 65.3% of the participants related that they had never done so. As well, 70.4% of the survey respondents stated that they would never keep a confidence regarding the patient or client from the treatment team at the request of a patient or client. Table 45 illustrates the respondents' reported behaviours around secrecy and keeping confidences.

Table 45

Behaviour Around Secrecy and Keeping Confidences

Rating of Frequency	Frequency	Percentage
Asked a Patient to Keep a Confidence From the Treatment Team		
Never	882	95.6
Rarely	25	2.7
Sometimes	2	0.2
Often	1	0.1
Always	0	0
No response	13	1.4
Kept a Patient Confidence Regarding Others in Patient's Life		
Never	603	65.3
Rarely	198	21.5
Sometimes	91	9.9
Often	8	0.9
Always	4	0.4
No response	19	2.1
Kept a Patient Confidence From the Treatment Team		
Never	650	70.4
Rarely	187	20.3
Sometimes	60	6.5
Often	6	0.7
Always	3	0.3
No response	17	1.8

(table continues)

Rating of Frequency	Frequency	Percentage
Kept a Patient Confidence Regarding Patient's Safety		
Never	871	94.4
Rarely	27	2.9
Sometimes	7	0.8
Often	2	0.2
Always	2	0.2
No response	14	1.5
Kept a Patient Confidence Regarding Other's Safety		
Never	847	91.8
Rarely	43	4.7
Sometimes	14	1.5
Often	2	0.2
Always	2	0.2
No response	15	1.6

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were examined to determine if there was a significant relationship between the *age* of the respondents and their behaviours around confidentiality and secrecy when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in keeping a confidence regarding the safety of the patient or client from the treatment team at the request of the patient or client based on age. Therefore, the null hypothesis that the respondents, regardless of age, have similar behaviours around confidentiality and secrecy was rejected. Table 46 illustrates the comparison of the behaviours around confidentiality and secrecy reported by the respondents based on age.

Table 46

Analysis of Variance for Behaviours Around Confidentiality and Secrecy by Age

Source	df	F Age	Sig.
Asked a Patient to Keep a Confidence From the Treatment Team			
Between groups	4	1.623	0.166
Within groups	886		
Kept a Patient Confidence Regarding Others in Patient's Life			
Between groups	4	0.854	0.491
Within groups	880		
Kept a Patient Confidence From the Treatment Team			
Between groups	4	0.403	0.807
Within groups	882		
Kept a Patient Confidence Regarding Patient's Safety			
Between groups	4	3.458	0.008*
Within groups	885		
Kept a Patient Confidence Regarding Other's Safety			
Between groups	4	1.277	0.277
Within groups	884		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *gender* of the respondents and their behaviours around confidentiality and secrecy when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in asking a patient or client to keep a confidence from the treatment team based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar behaviours around confidentiality and secrecy was rejected. Table 47 illustrates the comparison of the behaviours around confidentiality and secrecy by the respondents based on gender.

Table 47

Analysis of Variance for Behaviours Around Confidentiality and Secrecy by Gender

Source	df	F Gender	Sig.
Asked a Patient to Keep a Confidence From the Treatment Team			
Between groups	1	12.089	0.001*
Within groups	901		
Kept a Patient Confidence Regarding Others in Patient's Life			
Between groups	1	0.087	0.768
Within groups	895		
Kept a Patient Confidence From the Treatment Team			
Between groups	1	1.053	0.305
Within groups	897		
Kept a Patient Confidence Regarding Patient's Safety			
Between groups	1	0.395	0.530
Within groups	900		
Kept a Patient Confidence Regarding Other's Safety			
Between groups	1	0.014	0.905
Within groups	899		

Note. * $p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status*, *nursing education*, *years of experience*, and *specialty area* of the respondents and their behaviours around confidentiality and secrecy. No significant relationship was found in the ANOVAs. Therefore, the null hypothesis that the respondents, regardless of marital status, nursing education, years of experience, and specialty area, have similar behaviours around confidentiality and secrecy was accepted.

The data were examined to determine if there was a significant relationship between the *current work area* of the respondents and their behaviours around confidentiality and secrecy when interacting with patients and clients. The cross tabulation results indicated that nurses working in group therapy were the most likely to report that they had never kept a confidence regarding the patient or client from the treatment team at the request of the patient or client (81.8%), whereas the nurses who reported that they were not currently working were the least likely (47.6%). There was also a significant difference, as shown in the ANOVA, in the behaviours of the respondents in keeping a confidence regarding the patient or client from the treatment team at the request of the patient or client based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar behaviours around confidentiality and secrecy was rejected. Table 48 illustrates the comparison of the behaviours around confidentiality and secrecy by the respondents based on current work area.

Table 48

Analysis of Variance for Behaviours Around Confidentiality and Secrecy by Current Work Area

		F	
Source	df	Current Work Area	Sig.
Asked a Patient to Keep a Confidence From the Treatment Team			
Between groups	6	1.185	0.312
Within groups	885		
Kept a Patient Confidence Regarding Others in Patient's Life			
Between groups	6	1.872	0.083
Within groups	879		
Kept a Patient Confidence From the Treatment Team			
Between groups	6	3.493	0.002*
Within groups	881		
Kept a Patient Confidence Regarding Patient's Safety			
Between groups	6	0.478	0.825
Within groups	884		
Kept a Patient Confidence Regarding Other's Safety			
Between groups	6	1.095	0.363
Within groups	883		

Note. * $p < 0.05$.

The data were examined to determine if there was a significant relationship between the *workplace location* of the respondents and their behaviours around confidentiality and secrecy when interacting with patients and clients. As indicated by the cross tabulation results, the participants working in a city of over 500,000 were more likely to report that they had never kept a confidence regarding the patient or client from the treatment team at the request of the patient or client (75.9%). Nurses working in a rural area (57.7%) or town (63.4%) were the least likely to report that they had never kept a confidence regarding the patient or client from the treatment team at the request of the patient or client. There was also a significant difference, as shown in the ANOVA, in the behaviours of the respondents in keeping a confidence regarding the patient or client from the treatment team at the request of the patient or client based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar behaviours around confidentiality and secrecy was rejected. Table 49 illustrates the comparison of the behaviours around confidentiality and secrecy reported by the respondents based on workplace location.

Table 49

Analysis of Variance for Behaviours Around Confidentiality and Secrecy by Workplace Location

Source	df	F Workplace Location	Sig.
Asked a Patient to Keep a Confidence From the Treatment Team			
Between groups	4	0.402	0.807
Within groups	865		
Kept a Patient Confidence Regarding Others In Patient's Life			
Between groups	4	2.369	0.051
Within groups	859		
Kept a Patient Confidence From the Treatment Team			
Between groups	4	4.841	0.001*
Within groups	861		

(table continues)

Source	df	F Workplace Location	Sig.
Kept a Patient Confidence Regarding Patient's Safety			
Between groups	4	0.747	0.560
Within groups	865		
Kept a Patient Confidence Regarding Other's Safety			
Between groups	4	0.507	0.731
Within groups	863		

Note. * $p < 0.05$.

The data were examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their behaviours around confidentiality and secrecy. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar behaviours around confidentiality and secrecy was accepted.

In summary, in an examination of the attitudes toward confidentiality and secrecy, the null hypotheses that all mental health nurses, regardless of (a) marital status, (b) years of experience, and (c) amount of time worked, have similar attitudes toward confidentiality and secrecy were accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) gender, (c) nursing education, (d) specialty area, (e) current work area, (f) workplace location, have similar attitudes toward confidentiality and secrecy were rejected. As well, the null hypotheses that all mental health nurses, regardless of (a) marital status, (b) nursing education, (c) years of experience, (d) specialty area, and (e) amount of time worked, have similar behaviours around confidentiality and secrecy were accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) gender, (c) current work area, and (d) workplace location, have similar behaviours around confidentiality and secrecy were rejected.

Personal Space

To determine the respondents' attitudes about personal space when interacting with mental health patients, the survey participants were asked how appropriate it was to (a) use therapeutic massage with a patient or client, (b) hold a patient's or client's hand, (c) put their arm around a patient or client, (d) hug a patient or client, and (e) kiss a patient or client. The respondents were also asked to relate their own behaviours with patients and clients regarding personal space by indicating how often they had (a) used therapeutic massage with a patient or client, (b) held a patient or client's hand, (c) put their arm around a patient or client, (d) hugged a patient or client, (e) kissed a patient or client. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables concerning the personal space attitudes and behaviours were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

Personal Space Attitudes

When asked if it was appropriate to kiss a patient or client, 86.8% of the respondents indicated that they strongly disagreed. However, far fewer participants strongly disagreed that it was appropriate to hold a patient's or client's hand (8.0%), put an arm around a patient or client (9.6%), and hug a patient or client (14.8%). As well, 34.6% of the respondents in this survey strongly disagreed that it was appropriate to use therapeutic massage with a patient or client. Table 50 illustrates the respondents' attitudes toward personal space in patient interactions.

Table 50

Attitudes Toward Personal Space

Rating of Frequency	Frequency	Percentage
OK to Use Therapeutic Massage with a Patient		
Strongly disagree	319	34.6
Disagree somewhat	138	15.0
Neutral	219	23.7
Agree somewhat	114	12.4
Strongly agree	90	9.8
No response	43	4.7
OK to Hold a Patient's Hand		
Strongly disagree	74	8.0
Disagree somewhat	122	13.2
Neutral	288	31.2
Agree somewhat	209	22.6
Strongly agree	223	24.2
No response	7	0.8

(table continues)

Rating of Frequency	Frequency	Percentage
OK to Put Arm Around a Patient		
Strongly disagree	89	9.6
Disagree somewhat	148	16.0
Neutral	303	32.8
Agree somewhat	200	21.7
Strongly agree	175	19.0
No response	8	0.9
OK to Hug a Patient		
Strongly disagree	137	14.8
Disagree somewhat	171	18.5
Neutral	300	32.5
Agree somewhat	166	18.0
Strongly agree	142	15.4
No response	7	0.8
OK to Kiss a Patient		
Strongly disagree	801	86.8
Disagree somewhat	58	6.3
Neutral	41	4.4
Agree somewhat	11	1.2
Strongly agree	7	0.8
No Response	5	0.5

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were then examined to determine if there was a significant relationship between the *age* of the respondents and their attitudes toward personal space when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of holding a patient's or client's hand and putting their arm around a patient or client based on age. Therefore, the null hypothesis that the respondents, regardless of age, have similar attitudes toward personal space was rejected. Table 51 illustrates the comparison of the attitudes toward personal space reported by the respondents based on age.

Table 51

Analysis of Variance for Attitudes Toward Personal Space by Age

Source	df	F Age	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	4	0.941	0.439
Within groups	857		
OK to Hold a Patient's Hand			
Between groups	4	5.287	0.000*
Within groups	892		
OK to Put Arm Around a Patient			
Between groups	4	3.836	0.004*
Within groups	891		
OK to Hug a Patient			
Between groups	4	1.713	0.145
Within groups	892		
OK to Kiss a Patient			
Between groups	4	2.166	0.071
Within groups	894		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *gender* of the respondents and their attitudes toward personal space when interacting with patients and clients. The cross tabulation results indicated that 25.2% of female respondents strongly agreed that it was appropriate to hold a patient's or client's hand, but only 18.8% of the male respondents did so. As well, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of holding a patient's or client's hand based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar attitudes toward personal space was rejected. Table 52 illustrates the comparison of the attitudes toward personal space reported by the respondents based on gender.

Table 52

Analysis of Variance for Attitudes Toward Personal Space by Gender

Source	df	F Gender	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	1	0.707	0.401
Within groups	872		
OK to Hold a Patient's Hand			
Between groups	1	4.827	0.028*
Within groups	907		
OK to Put Arm Around a Patient			
Between groups	1	3.538	0.060
Within groups	906		
OK to Hug a Patient			
Between groups	1	1.597	0.207
Within groups	907		
OK to Kiss a Patient			
Between groups	1	1.009	0.315
Within groups	909		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status* and *nursing education* of the respondents and their attitudes toward personal space. No significant relationship was found in the ANOVAs. Therefore, the null hypothesis that the respondents, regardless of marital status and nursing education, have similar attitudes toward personal space was accepted.

The data were then examined to determine if there was a significant relationship between the *years of experience* of the respondents and their attitudes toward personal space when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of using therapeutic massage, holding a patient's or client's hand, putting their arm around a patient or client, and hugging a patient or client based on years of experience. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar attitudes toward personal space was rejected. Table 53 illustrates the comparison of the attitudes toward personal space reported by the respondents based on years of experience.

Table 53

Analysis of Variance for Attitudes Toward Personal Space by Years of Experience

		F	
Source	**df**	**Years of Experience**	**Sig.**
OK to Use Therapeutic Massage with a Patient			
Between groups	4	3.291	0.011*
Within groups	852		
OK to Hold a Patient's Hand			
Between groups	4	6.823	0.000*
Within groups	887		
OK to Put Arm Around a Patient			
Between groups	4	2.898	0.021*
Within groups	886		
OK to Hug a Patient			
Between groups	4	4.565	0.001*
Within groups	887		
OK to Kiss a Patient			
Between groups	4	0.418	0.796
Within groups	889		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *specialty area* of the respondents and their attitudes toward personal space when interacting with patients and clients. The cross tabulation results indicated that the participants specializing in forensic nursing were the most likely to strongly disagree that it was appropriate to use therapeutic massage (60.0%), put their arm around a patient or client (26.2%), hug a patient or client (42.9%), and kiss a patient or client (95.2%). On the other hand, participants specializing in geriatric nursing were the least likely to strongly disagree that it was appropriate to use therapeutic massage (16.8%), put their arm around a patient or client (2.9%), hug a patient or client (7.4%), and kiss a patient or client (66.2%). Nurses specializing in group therapy (17.9%) and forensic nursing (16.7%) were the most likely to strongly disagree that it was appropriate to hold a patient's or client's hand, whereas those nurses working in geriatric nursing (2.9%) and those not currently working (1.9%) were the least likely to strongly disagree.

As well, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of using therapeutic massage, holding a patient's or client's hand, putting their arm around a patient or client, hugging a patient or client, and kissing a patient or client based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar attitudes toward personal space was rejected. Table 54 illustrates the comparison of the attitudes toward personal space reported by the respondents based on specialty area.

Table 54

Analysis of Variance for Attitudes Toward Personal Space by Specialty Area

Source	df	F Specialty Area	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	6	6.275	0.000*
Within groups	840		
OK to Hold a Patient's Hand			
Between groups	6	8.493	0.000*
Within groups	872		
OK to Put Arm Around a Patient			
Between groups	6	8.105	0.000*
Within groups	871		
OK to Hug a Patient			
Between groups	6	10.483	0.000*
Within groups	872		
OK to Kiss a Patient			
Between groups	6	16.095	0.000*
Within groups	874		

Note. $^{*}p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *current work area* of the respondents and their attitudes toward personal space when interacting with patients and clients. The cross tabulation results indicated that the participants working in group therapy (57.6%) and forensic nursing (55.3%) were the most likely to strongly disagree that it was appropriate to use therapeutic massage. Participants working in geriatric nursing were the least likely to strongly disagree (17.8%). Again, nurses working in group therapy (20.6%) and forensic nursing (18.4%) were the most likely to strongly disagree that it was appropriate to hold a patient or client's hand. The participants working in geriatric nursing were the least likely to strongly disagree (2.1%). Participants working in forensic nursing were, again, the most likely to strongly disagree that it was appropriate to put their arm around a patient or client (28.6%) or hug a patient or client (44.9%). Geriatric nurses, once more, were the least likely to strongly disagree that it was appropriate to put their arm around a patient or client (2.1%) or hug a patient or client (4.9%). When asked about the appropriateness of kissing a patient or client, 97.1% of nurses working in group therapy and 95.9% of the respondents working in forensic nursing reported that they strongly disagreed. Only 65.5% of the participants working in geriatric nursing reported that they strongly disagreed.

As well, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of using therapeutic massage, holding a patient's or client's hand, putting their arm around a patient or client, hugging a patient or client, and kissing a patient or client based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar attitudes toward personal space was rejected. Table 55 illustrates the comparison of the attitudes toward personal space reported by the respondents based on current work area.

Table 55

Analysis of Variance for Attitudes Toward Personal Space by Current Work Area

Source	df	F Current Work Area	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	6	6.755	0.000*
Within groups	856		
OK to Hold a Patient's Hand			
Between groups	6	11.207	0.000*
Within groups	890		
OK to Put Arm Around a Patient			
Between groups	6	11.791	0.000*
Within groups	889		
OK to Hug a Patient			
Between groups	6	15.008	0.000*
Within groups	890		
OK to Kiss a Patient			
Between groups	6	16.059	0.000*
Within groups	892		

Note. $^*p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *workplace location* of the respondents and their attitudes toward personal space when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of putting their arm around a patient or client, hugging a patient or client, and kissing a patient or client based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar attitudes toward personal space was rejected. Table 56 illustrates the comparison of the attitudes toward personal space reported by the respondents based on workplace location.

Table 56

Analysis of Variance for Attitudes Toward Personal Space by Workplace Location

Source	df	F Workplace Location	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	4	0.463	0.763
Within groups	836		
OK to Hold a Patient's Hand			
Between groups	4	1.381	0.239
Within groups	871		
OK to Put Arm Around a Patient			
Between groups	4	2.469	0.043*
Within groups	870		
OK to Hug a Patient			
Between groups	4	4.090	0.003*
Within groups	872		
OK to Kiss a Patient			
Between groups	4	4.478	0.001*
Within groups	873		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their attitudes toward personal space when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of holding a patient's or client's hand, putting their arm around a patient or client, and hugging a patient or client based on the amount of time worked. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar attitudes toward personal space was rejected. Table 57 illustrates the comparison of the attitudes toward personal space reported by the respondents based on the amount of time worked.

Table 57

Analysis of Variance for Attitudes Toward Personal Space by Amount of Time Worked

Source	df	F Amt. of Time Worked	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	2	0.558	0.572
Within groups	849		
OK to Hold a Patient's Hand			
Between groups	2	4.919	0.008*
Within groups	883		
OK to Put Arm Around a Patient			
Between groups	2	4.525	0.011*
Within groups	882		

(table continues

Source	df	F	Sig.
		Amt. of Time Worked	
OK to Hug a Patient			
Between groups	2	3.721	0.025*
Within groups	883		
OK to Kiss a Patient			
Between groups	2	1.108	0.331
Within groups	885		

Note. $^{*}p < 0.05$.

Personal Space Behaviours

The vast majority (90.8%) related that they had never kissed a patient or client and therapeutic massage had never been utilized by 57.5% of the participants in this survey. However, only a small number of the respondents stated that they had never hugged a patient or client (17.4%), put their arm around a patient or client (11.5%), or held a patient or client's hand (11.1%). Table 58 outlines the respondents' reported behaviours around personal space in patient interactions.

Table 58

Behaviours Around Personal Space

Rating of Frequency	Frequency	Percentage
Used Therapeutic Massage		
Never	531	57.5
Rarely	198	21.5
Sometimes	136	14.7
Often	33	3.6
Always	5	0.5
No response	20	2.2

(table continues)

Rating of Frequency	Frequency	Percentage
Held a Patient's Hand		
Never	102	11.1
Rarely	226	24.5
Sometimes	396	42.8
Often	166	18.0
Always	30	3.3
No response	4	0.4
Put Arm Around a Patient		
Never	106	11.5
Rarely	294	31.9
Sometimes	371	40.2
Often	129	14.0
Always	18	2.0
No response	5	0.5
Hugged a Patient		
Never	161	17.4
Rarely	347	37.6
Sometimes	307	33.3
Often	86	9.3
Always	17	1.8
No response	5	0.5
Kissed a Patient		
Never	838	90.8
Rarely	50	5.4
Sometimes	20	2.2
Often	5	0.5
Always	3	0.3
No response	7	0.8

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were examined to determine if there was a significant relationship between the *age*, *gender*, and *marital status* of the respondents and their behaviours around personal space. No significant relationship was found in the ANOVAs. Therefore, the null hypothesis that the respondents, regardless of age, gender, and marital status, have similar behaviours around personal space was accepted.

The data were then examined to determine if there was a significant relationship between the *nursing education* of the respondents and their behaviours around personal space when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in kissing a patient or client, based on nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar behaviours around personal space was rejected. Table 59 illustrates the comparison of the behaviours around personal space reported by the respondents based on nursing education.

Table 59

Analysis of Variance for Behaviours Around Personal Space by Nursing Education

Source	df	F Nursing Education	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	5	1.600	0.157
Within groups	891		
OK to Hold a Patient's Hand			
Between groups	5	1.975	0.080
Within groups	907		
OK to Put Arm Around a Patient			
Between groups	5	1.266	0.277
Within groups	906		

(table continues)

Source	df	F Nursing Education	Sig.
OK to Hug a Patient			
Between groups	5	0.325	0.898
Within groups	906		
OK to Kiss a Patient			
Between groups	5	2.763	0.017*
Within groups	904		

Note. $*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *years of experience* of the respondents and their behaviours around personal space. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar behaviours around personal space was accepted.

The data were then examined to determine if there was a significant relationship between the *specialty area* of the respondents and their behaviours around personal space when interacting with patients and clients. The cross tabulation results indicated that the participants specializing in group therapy were the most likely to report that they had never used therapeutic massage (81.6%) or held a patient's or client's hand (28.2%). Nurses specializing in geriatric nursing were the least likely to report that they had never used therapeutic massage (33.8%) or held a patient or client's hand (2.2%). Participants specializing in forensic nursing were the most likely to report that they had never put their arm around a patient or client (31.0%) or hugged a patient or client (50.0%). Participants specializing in geriatric nursing were, again, the least likely to report that they had never put their arm around a patient or client (4.4%) or hugged a patient or client (8.1%). When asked to relate their behaviour around kissing a patient or client, only 69.4% of the participants who specialized in geriatric nursing reported that they had never done so, compared to those working in forensic nursing (97.6%), group therapy (97.4%), adult psychiatry (96.5%), other areas (94.1%), child and adolescent psychiatry (93.2%), or those not currently working (88.5%).

As well, there was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in using therapeutic massage, holding a patient's or client's hand, putting their arm around a patient or client, hugging a patient or client, and kissing a patient or client, based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar behaviours around personal space was rejected. Table 60 illustrates the comparison of the behaviours around personal space reported by the respondents based on specialty area.

Table 60

Analysis of Variance for Behaviours Around Personal Space by Specialty Area

Source	df	F Specialty Area	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	6	13.402	0.000*
Within groups	859		
OK to Hold a Patient's Hand			
Between groups	6	23.188	0.000*
Within groups	875		
OK to Put Arm Around a Patient			
Between groups	6	16.241	0.000*
Within groups	874		
OK to Hug a Patient			
Between groups	6	17.739	0.000*
Within groups	874		
OK to Kiss a Patient			
Between groups	6	20.138	0.000*
Within groups	872		

Note. *$p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *current work area* of the respondents and their behaviours around personal space when interacting with patients and clients. The cross tabulation results indicated that the participants working in group therapy were the most likely to report that they had never used therapeutic massage (79.4%), with the participants working in geriatric nursing the least likely (34.1%). Participants working in forensic nursing were the most likely report that they had never held a patient or client's hand (28.6%), put their arm around a patient or client (30.6%), or hugged a patient or client (55.1%). Again, participants working in geriatric nursing were the least likely to report that they had never held a patient's or client's hand (1.4%), put their arm around a patient or client (2.8%), or hugged a patient or client (7.7%). All (100%) of the participants working in group therapy and 98.0% of those working in forensic nursing reported that they had never kissed a patient or client. Only 70.7% of the participants working in geriatric nursing reported that they had never done so.

As well, there was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in using therapeutic massage, holding a patient's or client's hand, putting their arm around a patient or client, hugging a patient or client, and kissing a patient or client, based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar behaviours around personal space was rejected. Table 61 illustrates the comparison of the behaviours around personal space reported by the respondents based on current work area

Table 61

Analysis of Variance for Behaviours Around Personal Space by Current Work Area

		F	
Source	**df**	**Current Work Area**	**Sig.**
OK to Use Therapeutic Massage with a Patient			
Between groups	6	14.173	0.000*
Within groups	877		
OK to Hold a Patient's Hand			
Between groups	6	27.597	0.000*
Within groups	893		
OK to Put Arm Around a Patient			
Between groups	6	26.903	0.000*
Within groups	892		
OK to Hug a Patient			
Between groups	6	24.942	0.000*
Within groups	892		
OK to Kiss a Patient			
Between groups	6	16.365	0.000*
Within groups	890		

Note. $^*p < 0.05$.

The data were then examined to determine if there was a significant relationship between the *workplace location* of the respondents and their behaviours around personal space when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in using therapeutic massage, holding a patient's or client's hand, putting their arm around a patient or client, hugging a patient or client, and kissing a patient or client, based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar behaviours around personal space was rejected. Table 62 illustrates the comparison of the behaviours around personal space reported by the respondents based on workplace location.

Table 62

Analysis of Variance for Behaviours Around Personal Space by Workplace Location

Source	df	F Workplace Location	Sig.
OK to Use Therapeutic Massage with a Patient			
Between groups	4	3.127	0.014*
Within groups	860		
OK to Hold a Patient's Hand			
Between groups	4	2.724	0.028*
Within groups	874		
OK to Put Arm Around a Patient			
Between groups	4	8.246	0.000*
Within groups	873		
OK to Hug a Patient			
Between groups	4	7.177	0.000*
Within groups	873		
OK to Kiss a Patient			
Between groups	4	11.678	0.000*
Within groups	871		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their behaviours around personal space. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar behaviours around personal space was accepted.

In summary, in an examination of the attitudes toward personal space, the null hypotheses that all mental health nurses, regardless of marital status and nursing education, have similar attitudes toward personal space were accepted. The null hypotheses that all mental health nurses, regardless of (a*)* age, (b*)* gender, (c*)* years of experience, (d*)* specialty area, (e*)* current work area, (f*)* workplace location, and (g*)* amount of time worked, have similar attitudes toward personal space were rejected. As well, the null hypotheses that all mental health nurses, regardless of (a*)* age, (b*)* gender, (c*)* marital status, (d*)* years of experience, and (e*)* amount of time worked, have similar behaviours around personal space were accepted. The null hypotheses that all mental health nurses, regardless of (a*)* nursing education, (b*)* specialty area, (c*)* current work area, and (d*)* workplace location, have similar behaviours around personal space were rejected.

Boundary Violations

Dual Relationships and Sexual Misconduct

A *dual relationship* occurs when the nurse enters into an interpersonal relationship with the patient or client along with the therapeutic or helping relationship. *Sexual misconduct* occurs when a health professional violates professional boundaries with a patient or client and enters into an interpersonal relationship, which includes sexual intimacy. To determine the norms regarding dual relationships in a mental health setting, the survey participants were asked to indicate how strongly they felt that it was appropriate to (a) provide care (assessment or treatment services) to friends or family members, (b) comment to patients or clients on their physical attractiveness, (c) develop a friendship with a current patient or client, (d) develop a friendship with a patient or client following discharge, (e) participate in recreational or social activities outside of work with a current patient or client, and (f) participate in recreational or social activities outside of work with a patient or client following discharge. The participants were also asked to indicate how strongly they felt that it was appropriate to (a) invite a current patient or client to their home, (b) invite a patient or client to their home following discharge, (c) go on a date with a current patient or client, (d) go on a date with a patient or client following discharge, (e) have a sexual relationship with a current patient or client, and (f) have a sexual relationship with a patient or client following discharge.

To determine the respondents' behaviours around dual relationships, the survey participants were also asked to indicate how often they had (a) provided care (assessment or treatment services) to friends or family members, (b) commented to patient's or clients on their physical attractiveness, (c) developed a friendship with a current patient or client, (d) developed a friendship with a patient or client following discharge, (e) participated in recreational or social activities outside of work with a current patient or client, and (f) participated in recreational or social activities outside of work with a patient or client following discharge. The participants were also asked to indicate how often they had (a) invited a current patient or client to their home, (b) invited a patient or client to their home following discharge, (c) gone on a date with a current patient or client, (d) gone on a date with a patient or client following discharge, (e) had a sexual relationship with a current patient or client, and (f) had a sexual relationship with a patient or client following discharge.

The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables concerning the attitudes and behaviours toward dual relationships and sexual misconduct were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

Attitudes Toward Dual Relationships and Sexual Misconduct

When the respondents in this survey were asked to describe how appropriate they felt it was to provide assessment and treatment services to friends or family members, 33.2% indicated that they strongly disagreed that it was appropriate to provide such care to friends or family members. When asked about the appropriateness of commenting to patients or clients on their physical attractiveness, 34.6% of the respondents indicated that they strongly disagreed that it was appropriate. Most of the respondents reported that they strongly disagreed that it was appropriate to develop a friendship with a current patient or client (75.0%) or develop a friendship with a patient or client following discharge (66.2%). Similarly, 77.9% of the respondents reported that they strongly disagreed that it was appropriate to participate in recreational or social activities outside of work with a current patient or client, and 62.0% of the respondents indicated that they strongly disagreed that it was appropriate to participate in such activities following the discharge of a patient or client.

Most of the survey respondents indicated that they strongly disagreed that it was appropriate to invite a current (90.2%) or discharged (81.9%) patient or client to their home. Not surprisingly, 98.9 % of the respondents stated that they strongly disagreed with the statement that it was appropriate to date a current patient or client, and 91.9% strongly disagreed with the statement that it was appropriate to date a discharged patient or client. Unexpectedly, four respondents (0.4%) strongly agreed that it was appropriate to have a sexual relationship with a current patient. When asked about the appropriateness of having a sexual relationship with a patient or client following discharge, 4 respondents strongly agreed, 6 respondents agreed somewhat, and 7 respondents were neutral. Table 63 shows the respondents' attitudes toward dual relationships and sexual misconduct.

Table 63

Attitudes Toward Dual Relationships and Sexual Misconduct

Rating of Frequency	Frequency	Percentage
OK to Provide Care to Friends or Family		
Strongly disagree	306	33.2
Disagree somewhat	247	26.8
Neutral	229	24.8
Agree somewhat	82	8.9
Strongly agree	51	5.5
No response	8	0.9
OK to Comment on Physical Attractiveness		
Strongly disagree	319	34.6
Disagree somewhat	217	23.5
Neutral	268	29.0
Agree somewhat	80	8.7
Strongly agree	32	3.5
No response	7	0.8
OK to Develop a Friendship with a Current Patient		
Strongly disagree	692	75.0
Disagree somewhat	143	15.5
Neutral	60	6.5
Agree somewhat	18	2.0
Strongly agree	5	0.5
No response	5	0.5
OK to Develop a Friendship with a Discharged Patient		
Strongly disagree	611	66.2
Disagree somewhat	199	21.6
Neutral	82	8.9
Agree somewhat	23	2.5
Strongly agree	5	0.5
No response	3	0.3
OK to Socialize with a Patient Outside of Work		
Strongly disagree	719	77.9
Disagree somewhat	123	13.3
Neutral	57	6.2
Agree somewhat	11	1.2
Strongly agree	8	0.9
No response	5	0.5

(table continues)

Rating of Frequency	Frequency	Percentage
OK to Socialize with a Discharged Patient		
Strongly disagree	572	62.0
Disagree somewhat	220	23.8
Neutral	91	9.9
Agree somewhat	27	2.9
Strongly agree	10	1.1
No response	3	0.3
OK to Invite a Current Patient to your Home		
Strongly disagree	833	90.2
Disagree somewhat	53	5.7
Neutral	25	2.7
Agree somewhat	3	0.3
Strongly agree	5	0.5
No response	4	0.4
OK to Invite a Discharged Patient to your Home		
Strongly disagree	756	81.9
Disagree somewhat	99	10.7
Neutral	44	4.8
Agree somewhat	12	1.3
Strongly agree	4	0.4
No response	8	0.9
OK to Date a Current Patient		
Strongly disagree	913	98.9
Disagree somewhat	3	0.3
Neutral	0	0
Agree somewhat	0	0
Strongly agree	4	0.4
No response	3	0.3
OK to Date a Discharged Patient		
Strongly disagree	848	91.9
Disagree somewhat	54	5.9
Neutral	8	0.9
Agree somewhat	6	0.7
Strongly agree	4	0.4
No response	3	0.3

(table continues)

Rating of Frequency	Frequency	Percentage
OK to Have a Sexual Relationship with a Current Patient		
Strongly disagree	917	99.3
Disagree somewhat	0	0
Neutral	0	0
Agree somewhat	0	0
Strongly agree	4	0.4
No response	2	0.2
OK to Have a Sexual Relationship with a Discharged Patient		
Strongly disagree	868	94.0
Disagree somewhat	36	3.9
Neutral	7	0.8
Agree somewhat	6	0.7
Strongly agree	4	0.4
No response	2	0.2

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were examined to determine if there was a significant relationship between the *age* of the respondents and their attitudes toward dual relationships and sexual misconduct. The cross tabulations indicated that younger nurses (21 to 30 years of age) were the least likely to strongly disagree that it was appropriate to provide assessment or treatment services to family or friends (21.2%), develop a friendship with a current patient or client (69.2%), develop a friendship with a former patient or client (61.5%), date a patient or client following discharge (90.4%), or have sexual relationship with a patient or client following discharge (92.3%). However, younger nurses (21 to 30 years of age) were the most likely to strongly disagree that it was appropriate to participate in recreational or social activities outside of work with a current patient or client (86.5%) invite a current patient or client to their home (96.2%), date a current patient or client (100%), or have a sexual relationship with a current patient or client (100%). Older nurses (61 to 70 years of age) were the least likely to strongly disagree that it was appropriate to comment to patients or clients on their physical attractiveness (28.6%), whereas nurses in the 31 to 40 age group were the most likely to do so (40.8%). No significant relationship was found in ANOVA. Therefore, the null hypothesis that the respondents, regardless of age, have similar attitudes toward dual relationships and sexual misconduct was accepted.

The data were examined to determine if there was a significant relationship between the *gender* of the respondents and their attitudes toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the male respondents were slightly more likely to strongly disagree that it was appropriate to comment to patients or clients on their physical attractiveness. The female respondents were more likely to strongly disagreed that it was appropriate to interact with current or discharged patients in all of the rest of the dual relationship situations described in the survey.

As well, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of developing a friendship with a current patient or client, developing a friendship with a patient or client following discharge, participating in recreational or social activities outside of work with a current patient or client, and inviting a current patient or client to their home based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar attitudes toward dual relationships and sexual misconduct was rejected. Table 64 illustrates the comparison of the attitudes toward dual relationships and sexual misconduct reported by the respondents based on gender.

Table 64

Analysis of Variance of Attitudes Toward Dual Relationships and Sexual Misconduct by Gender

Source	df	F Gender	Sig.
OK to Provide Care to Friends or Family			
Between groups	1	2.901	0.089
Within groups	906		
OK to Comment on Physical Attractiveness			
Between groups	1	0.202	0.653
Within groups	908		
OK to Develop a Friendship with a Current Patient			
Between groups	1	11.434	0.001**
Within groups	909		
OK to Develop a Friendship with a Discharged Patient			
Between groups	1	4.508	0.034*
Within groups	911		
OK to Socialize with a Patient Outside of Work			
Between groups	1	8.851	0.003**
Within groups	909		
OK to Socialize with a Discharged Patient			
Between groups	1	2.727	0.099
Within groups	911		
OK to Invite a Current Patient to your Home			
Between groups	1	5.130	0.024*
Within groups	910		

(table continues)

Source	df	F Gender	Sig.
OK to Invite a Discharged Patient to your Home			
Between groups	1	2.606	0.107
Within groups	907		
OK to Date a Current Patient			
Between groups	1	0.979	0.323
Within groups	911		
OK to Date a Discharged Patient			
Between groups	1	0.738	0.390
Within groups	911		
OK to Have a Sexual Relationship with a Current Patient			
Between groups	1	0.243	0.622
Within groups	912		
OK to Have a Sexual Relationship with a Discharged Patient			
Between groups	1	1.331	0.249
Within groups	912		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status* of the respondents and their attitudes toward dual relationships and sexual misconduct. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar attitudes toward dual relationships and sexual misconduct was accepted.

The data were then examined to determine if there was a significant relationship between the *nursing education* of the respondents and their attitudes toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that diploma RNs were the most likely to strongly disagree that it was appropriate to participate in recreational or social activities outside of work with a current patient or client (81%), participate in recreational or social activities outside of work with a patient or client following discharge (63.6%), invite a current patient or client to their home (94.2%), and invite a patient or client to their home following discharge (86.1%). Nurses who reported their education as other (Bachelor of Science in Mental Health) were the least likely to strongly disagree that it was appropriate. These findings should be interpreted with caution, because only three participants reported their education as other.

There was, as well, a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of developing a friendship with a current patient or client, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, inviting a current patient or client to their home, and inviting a patient or client to their home following discharge based on nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar attitudes toward dual relationships and sexual misconduct was rejected. Table 65 illustrates the comparison of the attitudes toward dual relationships and sexual misconduct reported by the respondents based on nursing education.

Table 65

Analysis of Variance of Attitudes Toward Dual Relationships and Sexual Misconduct by Nursing Education

Source	df	F Nursing Education	Sig.
OK to Provide Care to Friends or Family			
Between groups	5	1.667	0.140
Within groups	903		
OK to Comment on Physical Attractiveness			
Between groups	5	1.391	0.225
Within groups	904		
OK to Develop a Friendship with a Current Patient			
Between groups	5	2.478	0.031*
Within groups	906		
OK to Develop a Friendship with a Discharged Patient			
Between groups	5	1.716	0.128
Within groups	908		
OK to Socialize with a Patient Outside of Work			
Between groups	5	2.567	0.026*
Within groups	906		
OK to Socialize with a Discharged Patient			
Between groups	5	4.332	0.001*
Within groups	908		
OK to Invite a Current Patient to your Home			
Between groups	5	4.205	0.001*
Within groups	907		
OK to Invite a Discharged Patient to your Home			
Between groups	5	3.386	0.005*
Within groups	903		

(table continues)

Source	df	F Nursing Education	Sig.
OK to Date a Current Patient			
Between groups	5	0.124	0.987
Within groups	908		
OK to Date a Discharged Patient			
Between groups	5	1.222	0.296
Within groups	908		
OK to Have a Sexual Relationship with a Current Patient			
Between groups	5	0.062	0.997
Within groups	909		
OK to Have a Sexual Relationship with a Discharged Patient			
Between groups	5	0.610	0.692
Within groups	909		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *years of experience* of the respondents and their attitudes toward dual relationships and sexual misconduct. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar attitudes toward dual relationships and sexual misconduct was accepted.

The data were examined to determine if there was a significant relationship between the *specialty area* of the respondents and their attitudes toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the participants specializing in geriatrics were the most likely to strongly agree that it was appropriate to provide assessment and treatment services to friends or family members (11.0%), whereas nurses specializing in child and adolescent mental health were the least likely to strongly agree (2.7%). The participants specializing in group therapy (92.5%) and forensic nursing (88.1%) were the most likely to report that they strongly disagreed that it was appropriate to develop a friendship with a current patient or client. Respondents specializing in geriatric nursing were the least likely to report that they strongly disagreed (55.6%).

The participants specializing in forensic nursing were the most likely to report that they strongly disagreed that it was appropriate to develop a friendship with a patient or client following discharge (92.9%), participate in recreational or social activities outside of work with a current patient or client (95.2%), participate in recreational or social activities outside of work with a patient or client following discharge (88.1%), invite a current patient or client to their home (100%), or invite a patient or client to their home following discharge (97.6%). Again, the nurses specializing in geriatrics were the least likely to report that they strongly disagreed that it was appropriate to develop a friendship with a patient or client following discharge (54.4%), participate in recreational or social activities outside of work with a current patient or client (66.9%), participate in recreational or social activities outside of work with a patient or client following discharge (51.5%), invite a current patient or client to their home (83.1%), and invite a patient or client to their home following discharge (75.6%).

As well, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of providing assessment and treatment services to friends or family members, developing a friendship with a current patient or client, developing a friendship with a patient or client following discharge, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, inviting a current patient or client to their home, and inviting a patient or client to their home following discharge based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar attitudes toward dual relationships and sexual misconduct was rejected. Table 66 illustrates the comparison of the attitudes toward dual relationships and sexual misconduct reported by the respondents based on specialty area.

Table 66

Analysis of Variance of Attitudes Toward Dual Relationships and Sexual Misconduct by Specialty Area

Source	df	F Specialty Area	Sig.
OK to Provide Care to Friends or Family			
Between groups	6	2.890	0.009*
Within groups	872		
OK to Comment on Physical Attractiveness			
Between groups	6	0.707	0.644
Within groups	873		
OK to Develop a Friendship with a Current Patient			
Between groups	6	7.556	0.000*
Within groups	874		

(table continues)

		F	
Source	df	Specialty Area	Sig.
OK to Develop a Friendship with a Discharged Patient			
Between groups	6	4.703	0.000*
Within groups	876		
OK to Socialize with a Patient Outside of Work			
Between groups	6	3.480	0.002*
Within groups	875		
OK to Socialize with a Discharged Patient			
Between groups	6	4.947	0.000*
Within groups	876		
OK to Invite a Current Patient to your Home			
Between groups	6	4.372	0.000*
Within groups	875		
OK to Invite a Discharged Patient to your Home			
Between groups	6	3.674	0.001*
Within groups	872		
OK to Date a Current Patient			
Between groups	6	0.850	0.531
Within groups	876		
OK to Date a Discharged Patient			
Between groups	6	0.345	0.913
Within groups	876		
OK to Have a Sexual Relationship with a Current Patient			
Between groups	6	1.010	0.417
Within groups	877		
OK to Have a Sexual Relationship with a Discharged Patient			
Between groups	6	0.431	0.858
Within groups	877		

Note. $^{*}p < 0.05$.

The data were examined to determine if there was a significant relationship between the *current work area* of the respondents and their attitudes toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the participants currently working in group therapy were the most likely to strongly disagree that it was appropriate to develop a friendship with a current patient or client (91.2%). The respondents working in geriatric nursing were, again, the least likely to report that they strongly disagreed (57.4%). The respondents currently working in forensic nursing were the most likely to report that they strongly disagreed that it was appropriate to develop a friendship with a patient or client following discharge (91.8%), participate in recreational or social activities outside of work with a current patient or client (95.9%), participate in recreational or social activities outside of work with a patient or client following discharge (83.7%), invite a current patient or client to their home (100%), and invite a patient or client to their home following discharge (98.0%). Those nurses who indicated that they were not currently working were the least likely to report that they strongly disagreed that it was appropriate to develop a friendship with a patient or client following discharge (52.4%), participate in recreational or social activities outside of work with a patient or client following discharge (47.6%), invite a current patient or client to their home (76.2%), or invite a patient or client to their home following discharge (66.7%).

As well, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of providing assessment and treatment services to friends or family members, developing a friendship with a current patient or client, developing a friendship with a patient or client following discharge, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, inviting a current patient or client to their home, and inviting a patient or client to their home following discharge based on current work areas. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar attitudes toward dual relationships and sexual misconduct was rejected. Table 67 illustrates the comparison of the attitudes toward dual relationships and sexual misconduct reported by the respondents based on current work area.

Table 67

Analysis of Variance of Attitudes Toward Dual Relationships and Sexual Misconduct by Current Work Area

Source	df	F Current Work Area	Sig.
OK to Provide Care to Friends or Family			
Between groups	6	2.852	0.009*
Within groups	889		
OK to Comment on Physical Attractiveness			
Between groups	6	0.850	0.532
Within groups	891		
OK to Develop a Friendship with a Current Patient			
Between groups	6	8.409	0.000*
Within groups	892		

(table continues)

		F	
Source	**df**	**Current Work Area**	**Sig.**
OK to Develop a Friendship with a Discharged Patient			
Between groups	6	5.728	0.000*
Within groups	894		
OK to Socialize with a Patient Outside of Work			
Between groups	6	4.865	0.000*
Within groups	892		
OK to Socialize with a Discharged Patient			
Between groups	6	5.368	0.000*
Within groups	894		
OK to Invite a Current Patient to your Home			
Between groups	6	5.293	0.000*
Within groups	893		
OK to Invite a Discharged Patient to your Home			
Between groups	6	5.259	0.000*
Within groups	889		
OK to Date a Current Patient			
Between groups	6	1.283	0.263
Within groups	894		
OK to Date a Discharged Patient			
Between groups	6	4.85	0.819
Within groups	894		
OK to Have a Sexual Relationship with a Current Patient			
Between groups	6	1.436	0.198
Within groups	895		
OK to Have a Sexual Relationship with a Discharged Patient			
Between groups	6	0.664	0.679
Within groups	895		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *workplace location* of the respondents and their attitudes toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that those respondents working in a city of over 500,000 were the most likely to strongly disagree that it was appropriate to develop a friendship with a current patient or client (79.7%), participate in recreational or social activities outside of work with a current patient or client (87.1%), invite a current patient or client to their home (95.5%), or invite a patient or client to their home following discharge (87.4%).

As well there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of developing a friendship with a current patient or client, developing a friendship with a patient or client following discharge, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, inviting a current patient or client to their home, and inviting a patient or client to their home following discharge based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar attitudes toward dual relationships and sexual misconduct was rejected. Table 68 illustrates the comparison of the attitudes toward dual relationships and sexual misconduct reported by the respondents based on workplace location.

Table 68

Analysis of Variance of Attitudes Toward Dual Relationships and Sexual Misconduct by Workplace Location

Source	df	F Workplace Location	Sig.
OK to Provide Care to Friends or Family			
Between groups	4	0.752	0.557
Within groups	870		
OK to Comment on Physical Attractiveness			
Between groups	4	0.638	0.636
Within groups	871		
OK to Develop a Friendship with a Current Patient			
Between groups	4	8.726	0.000*
Within groups	873		
OK to Develop a Friendship with a Discharged Patient			
Between groups	4	9.669	0.000*
Within groups	875		
OK to Socialize with a Patient Outside of Work			
Between groups	4	23.989	0.000*
Within groups	873		
OK to Socialize with a Discharged Patient			
Between groups	4	13.377	0.000*
Within groups	875		
OK to Invite a Current Patient to your Home			
Between groups	4	17.068	0.000*
Within groups	874		
OK to Invite a Discharged Patient to your Home			
Between groups	4	7.053	0.000*
Within groups	870		

(table continues)

		F	
Source	df	Workplace Location	Sig.
OK to Date a Current Patient			
Between groups	4	0.486	0.746
Within groups	875		
OK to Date a Discharged Patient			
Between groups	4	0.802	0.524
Within groups	875		
OK to Have a Sexual Relationship with a Current Patient			
Between groups	4	0.278	0.892
Within groups	876		
OK to Have a Sexual Relationship with a Discharged Patient			
Between groups	4	0.444	0.777
Within groups	876		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their attitudes toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the nurses working full time were more likely to report that they strongly disagreed that it was appropriate to comment to patients or clients on their physical attractiveness (39.1%) than were the respondents working part time (31.9%) or more than full time (17.7%). As well, there was a significant difference, as shown in the ANOVA, in the attitudes of the respondents regarding the appropriateness of commenting to patients or clients on their physical attractiveness based on the amount of time worked. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar attitudes toward dual relationships and sexual misconduct was rejected. Table 69 illustrates the comparison of the attitudes toward dual relationships and sexual misconduct reported by the respondents based on the amount of time worked.

Table 69

Analysis of Variance of Attitudes Toward Dual Relationships and Sexual Misconduct by Amount of Time Worked

Source	df	F Amt. of Time Worked	Sig.
OK to Provide Care to Friends or Family			
Between groups	2	0.340	0.712
Within groups	882		
OK to Comment on Physical Attractiveness			
Between groups	2	5.557	0.004*
Within groups	884		
OK to Develop a Friendship with a Current Patient			
Between groups	2	0.556	0.574
Within groups	885		
OK to Develop a Friendship with a Discharged Patient			
Between groups	2	0.109	0.897
Within groups	887		
OK to Socialize with a Patient Outside of Work			
Between groups	2	0.883	0.414
Within groups	885		
OK to Socialize with a Discharged Patient			
Between groups	2	0.304	0.738
Within groups	887		

(table continues)

Source	df	F Amt. of Time Worked	Sig.
OK to Invite a Current Patient to your Home			
Between groups	2	0.303	0.738
Within groups	886		
OK to Invite a Discharged Patient to your Home			
Between groups	2	0.653	0.521
Within groups	882		
OK to Date a Current Patient			
Between groups	2	0.310	0.734
Within groups	887		
OK to Date a Discharged Patient			
Between groups	2	2.286	0.102
Within groups	887		
OK to Have a Sexual Relationship with a Current Patient			
Between groups	2	0.192	0.825
Within groups	888		
OK to Have a Sexual Relationship with a Discharged Patient			
Between groups	2	2.160	0.116
Within Groups	888		

Note. $^*p < 0.05$.

Behaviours Around Dual Relationships and Sexual Misconduct

When asked about their practice of providing assessment and treatment services to friends or family members, 35.9% of the respondents reported that they had never provided such care. As well, 34.6% related that they had never commented to a patient or client on their physical attractiveness. When asked about developing a friendship with a patient or client, 78.0% of the respondents reported that they had never done so with a current patient or client, and 82.1%

reported that they had never done so with a patient or client following discharge. The majority of the respondents had never socialized with a current patient or client outside of work (85.7%), and 79.7% had never socialized with a discharged patient or client. Similarly, 93.4% of the respondents had never invited a current patient or client to their home, and 92.0% had never invited a discharged patient or client to their home. As well, 98.8% of the participants related that they had never dated a current patient or client, and 97.9% related that they had never dated a discharged patient or client. When asked about developing a sexual relationship with a patient or client, none of the respondents reported that they had had a sexual relationship with a current patient or client, and 6 respondents (0.6%) reported that they rarely or sometimes had a sexual relationship with a discharged patient or client. Table 70 illustrates the respondents' reported behaviours around dual relationships and sexual misconduct.

Table 70

Behaviours Around Dual Relationships and Sexual Misconduct

Rating of Frequency	Frequency	Percentage
Provided Care to Friends or Family		
Never	331	35.9
Rarely	314	34.0
Sometimes	229	24.8
Often	30	3.3
Always	4	0.4
No response	15	1.6

(table continues)

Rating of Frequency	Frequency	Percentage
Commented on Physical Attractiveness		
Never	319	34.6
Rarely	297	32.2
Sometimes	249	27.0
Often	39	4.2
Always	4	0.4
No response	15	1.6
Developed a Friendship with a Current Patient		
Never	720	78.0
Rarely	133	14.4
Sometimes	48	5.2
Often	7	0.8
Always	3	0.3
No response	12	1.3
Developed a Friendship with a Discharged Patient		
Never	758	82.1
Rarely	127	13.8
Sometimes	25	2.7
Often	1	0.1
Always	0	0
No response	12	1.3
Socialized with a Patient Outside Work		
Never	791	85.7
Rarely	93	10.1
Sometimes	22	2.4
Often	4	0.4
Always	0	0
No response	13	1.4
Socialized with a Discharged Patient		
Never	736	79.7
Rarely	142	15.4
Sometimes	27	2.9
Often	5	0.5
Always	0	0
No response	13	1.4

(table continues)

Rating of Frequency	Frequency	Percentage
Invited a Current Patient to their Home		
Never	862	93.4
Rarely	40	4.3
Sometimes	7	0.8
Often	3	0.3
Always	0	0
No response	11	1.2
Invited a Discharged Patient to their Home		
Never	849	92.0
Rarely	55	6.0
Sometimes	8	0.9
Often	1	0.1
Always	0	0
No response	10	1.1
Dated a Current Patient		
Never	912	98.8
Rarely	1	0.1
Sometimes	0	0
Often	0	0
Always	0	0
No response	10	1.1
Dated a Discharged Patient		
Never	904	97.9
Rarely	8	0.9
Sometimes	1	0.1
Often	0	0
Always	0	0
No response	10	1.1
Had a Sexual Relationship with a Current Patient		
Never	913	98.9
Rarely	0	0
Sometimes	0	0
Often	0	0
Always	0	0
No response	10	1.1

(table continues)

Rating of Frequency	Frequency	Percentage
Had a Sexual Relationship with a Discharged Patient		
Never	907	98.3
Rarely	5	0.5
Sometimes	1	0.1
Often	0	0
Always	0	0
No response	10	1.1

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

The data were examined to determine if there was a significant relationship between the *age* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that younger nurses (21 to 30 years of age) were the least likely to report that they had never provided assessment or treatment services to friends or family members (27.5%) or commented to patients or clients on their physical attractiveness (29.4%). Younger nurses (21 to 30 years of age) were also the most likely to report that they had never developed a friendship with a current patient or client (84.3%), developed a friendship with a patient or client following discharge (90.2%), participated in recreational or social activities outside of work with a current patient or client (98.0%), participated in recreational or social activities outside of work with a patient or client following discharge (88.2%), or invited a current patient or client to their home (98.0%). They were also among the nurses who reported that they had never dated a current patient or client, dated a patient or client following discharge, had a sexual relationship with a current patient or client, or had a sexual relationship with patient or client following discharge. One nurse in the 51 to 60 age group reported that he or she had dated a current patient or client (rarely). Two nurses in the 41 to 50 age group and five nurses the 51 to 60 age group were the only individuals to report that they had dated a former patient or client. None of the respondents reported that they had a sexual relationship with a current patient or client. One nurse in the 31 to 40, and 41 to 50, age group and three nurses in the 51 to 60 age group were the only individuals to report that they had a sexual relationship with a discharged patient or client (rarely).

There was also a significant difference, as shown in the ANOVA, in the behaviours of the respondents in developing a friendship with a current patient or client, participating in recreational or social activities outside of work with a current patient or client, and inviting a patient or client to their home following discharge based on age. Therefore, the null hypothesis that the respondents, regardless of age, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 71 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on age.

Table 71

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Age

		F	
Source	**df**	**Age**	**Sig.**
Provided Care to Friends or Family			
Between groups	4	1.750	0.137
Within groups	884		
Commented on a Patient's Physical Attractiveness			
Between groups	4	1.491	0.203
Within groups	885		
Developed a Friendship with a Current Patient			
Between groups	4	2.630	0.033*
Within groups	887		
Developed a Friendship with a Discharged Patient			
Between groups	4	1.648	0.160
Within groups	887		
Socialized with a Patient Outside of Work			
Between groups	4	2.592	0.035*
Within groups	886		
Socialized with a Discharged Patient			
Between groups	4	1.586	0.176
Within groups	886		
Invited a Current Patient to your Home			
Between groups	4	1.921	0.105
Within groups	888		
Invited a Discharged Patient to your Home			
Between groups	4	3.024	0.017*
Within groups	889		

(table continues)

		F	
Source	**df**	**Age**	**Sig.**
Dated a Current Patient			
Between groups	4	0.712	0.584
Within groups	889		
Dated a Discharged Patient			
Between groups	4	2.095	0.080
Within groups	889		
Had a Sexual Relationship with a Current Patient			
Between groups	4	.	.
Within groups	889		
Had a Sexual Relationship with a Discharged Patient			
Between groups	4	0.800	0.525
Within groups	889		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *gender* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the male respondents were more likely to report that they had never commented to patients or clients on their physical attractiveness. The female respondents were more likely to report that they had never interacted with current or discharged patients in any of the rest of the dual relationship situations described in the survey. Female respondents (82.3%) were also more likely to report that they had never developed a friendship with a current patient or client than were male respondents (61.5%).

Only 1 (0.7%) male participant reported that he had rarely dated a current patient or client, and only 5 (0.7%) female and 2 (1.4%) male participants reported that they had dated a patient or client following discharge. No respondents reported that they had a sexual relationship with a current patient or client. However, 4 (0.5%) female and 1(0.7%) male participants reported that they had rarely had a sexual relationship with a patient or client following discharge.

As well, there was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in developing a friendship with a current patient or client, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, dating a current patient or client, and dating a patient or client following discharge based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 72 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on gender.

Table 72

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Gender

Source	df	F Gender	Sig.
Provided Care to Friends or Family			
Between groups	1	1.419	0.234
Within groups	899		
Commented on a Patient's Physical Attractiveness			
Between groups	1	1.517	0.218
Within groups	900		
Developed a Friendship with a Current Patient			
Between groups	1	28.985	0.000*
Within groups	902		
Developed a Friendship with a Discharged Patient			
Between groups	1	2.353	0.125
Within groups	902		
Socialized with a Patient Outside of Work			
Between groups	1	11.941	0.001*
Within groups	901		
Socialized with a Discharged Patient			
Between groups	1	4.231	0.040*
Within groups	901		
Invited a Current Patient to your Home			
Between groups	1	1.479	0.224
Within groups	903		
Invited a Discharged Patient to your Home			
Between groups	1	1.831	0.176
Within groups	904		

(table continues)

		F	
Source	**df**	**Gender**	**Sig.**
Dated a Current Patient			
Between groups	1	5.361	0.021*
Within groups	904		
Dated a Discharged Patient			
Between groups	1	4.601	0.032*
Within groups	904		
Had a Sexual Relationship with a Current Patient			
Between groups	1	.	.
Within groups	904		
Had a Sexual Relationship with a Discharged Patient			
Between groups	1	3.024	0.082
Within groups	904		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that nurses who were separated or divorced were the least likely to report that they had never invited a current patient or client to their home (88.7%), whereas those participants who were widowed reported that they had never done so (100%). Those participants who were widowed or living common law reported that they had never dated a patient or client following discharge (100%). Single nurses were the least likely to report that they had never dated a patient or client following discharge (96.3%). The participants who were single (96.3%) or married (99.5%) were the least likely to report that they had never had a sexual relationship with a patient or client following discharge. Participants who were widowed, separated, or divorced reported that they had never done so (100%). Three (0.5%) of the married and 3 (3.6%) of the single participants reported that they had a sexual relationship with a patient or client following discharge.

There was also a significant difference, as shown in the ANOVA, in the behaviours of the respondents in inviting a current patient or client to their home, dating a patient or client following discharge, and having a sexual relationship with a patient or client following discharge based on marital status. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 73 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on marital status.

Table 73

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Marital Status

Source	df	F Marital Status	Sig.
Provided Care to Friends or Family			
Between groups	4	0.661	0.619
Within groups	898		
Commented on a Patient's Physical Attractiveness			
Between groups	4	2.168	0.071
Within groups	898		

(table continues)

Source	df	F Marital Status	Sig.
Developed a Friendship with a Current Patient			
Between groups	4	1.574	0.179
Within groups	901		
Developed a Friendship with a Discharged Patient			
Between groups	4	1.682	0.152
Within groups	901		
Socialized with a Patient Outside of Work			
Between groups	4	1.485	0.205
Within groups	900		
Socialized with a Discharged Patient			
Between groups	4	2.062	0.084
Within groups	900		
Invited a Current Patient to your Home			
Between groups	4	3.372	0.009*
Within groups	902		
Invited a Discharged Patient to your Home			
Between groups	4	1.495	0.202
Within groups	903		
Dated a Current Patient			
Between groups	4	0.115	0.977
Within groups	903		
Dated a Discharged Patient			
Between groups	4	2.929	0.020*
Within groups	903		
Had a Sexual Relationship with a Current Patient			
Between groups	4	.	.
Within groups	903		
Had a Sexual Relationship with a Discharged Patient			
Between groups	4	3.997	0.003*
Within groups	903		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *nursing education* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation indicated that nurses who reported their education as other (Bachelor of Science in Mental Health) were the least likely to report that they never developed a friendship with a current patient or client (66.7%), developed a friendship with a patient or client following discharge (33.3%), or invited a current patient or client to their home (66.7%). These results should again be interpreted with caution because only three participants reported their education as other. The cross tabulation indicated that diploma RPNs were then the least likely to report that they never developed a friendship with a current patient or client (74.5%), developed a friendship with a patient or client following discharge (80.6%), invited a current patient or client to their home (92.4%), dated a patient or client following discharge (98.8%), or had a sexual relationship with a patient or client following discharge (99.1%). One diploma RN (0.3%), one (0.6%) BScN and 4 (0.9%) diploma RPNs reported that they had a sexual relationship with a patient or client following discharge.

There was a also significant difference, as shown in the ANOVA, in the behaviours of the respondents in developing a friendship with a current patient or client, developing a friendship with a patient or client following discharge, and inviting a current patient or client to their home based on nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 74 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on nursing education.

Table 74

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Nursing Education

Source	df	F Nursing Education	Sig.
Provided Care to Friends or Family			
Between groups	5	1.698	0.133
Within groups	896		
Commented on a Patient's Physical Attractiveness			
Between groups	5	1.881	0.095
Within groups	896		
Developed a Friendship with a Current Patient			
Between groups	5	2.639	0.022*
Within groups	899		
Developed a Friendship with a Discharged Patient			
Between groups	5	5.377	0.000*
Within groups	899		
Socialized with a Patient Outside of Work			
Between groups	5	1.287	0.267
Within groups	898		
Socialized with a Discharged Patient			
Between groups	5	1.416	0.216
Within groups	898		

(table continues)

Source	df	F	Sig.
		Nursing Education	
Invited a Current Patient to your Home			
Between groups	5	4.285	0.001*
Within groups	900		
Invited a Discharged Patient to your Home			
Between groups	5	0.805	0.546
Within groups	901		
Dated a Current Patient			
Between groups	5	0.218	0.955
Within groups	901		
Dated a Discharged Patient			
Between groups	5	0.231	0.949
Within groups	901		
Had a Sexual Relationship with a Current Patient			
Between groups	5	.	.
Within groups	901		
Had a Sexual Relationship with a Discharged Patient			
Between groups	5	0.273	0.928
Within groups	901		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *years of experience* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. There was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in participating in recreational or social activities outside of work with a patient or client following discharge based on years of experience. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 75 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on years of experience.

Table 75

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Years of Experience

		F	
Source	**df**	**Years of Experience**	**Sig.**
Provided Care to Friends or Family			
Between groups	4	1.796	0.127
Within groups	880		
Commented on a Patient's Physical Attractiveness			
Between groups	4	0.246	0.912
Within groups	881		
Developed a Friendship with a Current Patient			
Between groups	4	0.291	0.884
Within groups	883		
Developed a Friendship with a Discharged Patient			
Between groups	4	1.316	0.262
Within groups	883		
Socialized with a Patient Outside of Work			
Between groups	4	0.818	0.514
Within groups	883		
Socialized with a Discharged Patient			
Between groups	4	3.316	0.010*
Within groups	883		

(table continues)

		F	
Source	**df**	**Years of Experience**	**Sig.**
Invited a Current Patient to your Home			
Between groups	4	1.270	0.280
Within groups	884		
Invited a Discharged Patient to your Home			
Between groups	4	1.440	0.219
Within groups	885		
Dated a Current Patient			
Between groups	4	0.804	0.523
Within groups	885		
Dated a Discharged Patient			
Between groups	4	0.218	0.929
Within groups	885		
Had a Sexual Relationship with a Current Patient			
Between groups	4	.	.
Within groups	885		
Had a Sexual Relationship with a Discharged Patient			
Between groups	4	0.103	0.981
Within groups	885		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *specialty area* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the respondents who specialized in group therapy were the most likely to report that they had never provided assessment and treatment services to friends or family members (46.2%) or developed a friendship with a current patient or client (92.5%). The respondents who reported that they had no specialty area were the least likely to report that they had never provided assessment and treatment services to friends or family members (28%). The respondents specializing in geriatric nursing were the least likely to report that they had never developed a friendship with a current patient or client (62.7%). The participants specializing in forensic nursing were the most likely to report that they had never participated in recreational or social activities outside of work with a current patient or client (100%), participated in recreational or social activities outside of work with a patient or client following discharge (97.6%), or invited a current patient or client to their home (100%). The participants specializing in child and adolescent mental health were the least likely to report that they had never participated in recreational or social activities outside of work with a current patient or client (80.8%), participated in recreational or social activities outside of work with a patient or client following discharge (71.2%), or invited a current patient or client to their home (90.4%). The participants specializing in geriatric nursing also reported that they had never invited a current patient or client to their home (90.4%). All six (1.3%) of the participants who reported that they had a sexual relationship with a patient or client following discharge specialized in adult psychiatry.

As well, there was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in providing assessment and treatment services to friends or family members, developing a friendship with a current patient or client, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, and inviting a current patient or client to their home based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 76 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on specialty area.

Table 76

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Specialty Area

		F	
Source	**df**	**Specialty Area**	**Sig.**
Provided Care to Friends or Family			
Between groups	6	2.188	0.042*
Within groups	866		
Commented on a Patient's Physical Attractiveness			
Between groups	6	0.921	0.479
Within groups	868		
Developed a Friendship with a Current Patient			
Between groups	6	5.863	0.000*
Within groups	869		
Developed a Friendship with a Discharged Patient			
Between groups	6	1.806	0.095
Within groups	870		
Socialized with a Patient Outside of Work			
Between groups	6	2.982	0.007*
Within groups	869		

(table continues)

		F	
Source	df	Specialty Area	Sig.
Socialized with a Discharged Patient			
Between groups	6	2.312	0.032*
Within groups	868		
Invited a Current Patient to your Home			
Between groups	6	2.986	0.007*
Within groups	870		
Invited a Discharged Patient to your Home			
Between groups	6	1.897	0.079
Within groups	871		
Dated a Current Patient			
Between groups	6	1.561	0.156
Within groups	871		
Dated a Discharged Patient			
Between groups	6	0.773	0.591
Within groups	871		
Had a Sexual Relationship with a Current Patient			
Between groups	6	.	.
Within groups	871		
Had a Sexual Relationship with a Discharged Patient			
Between groups	6	0.855	0.528
Within groups	871		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *current work area* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the respondents currently working in group therapy were the most likely to report that they had never developed a friendship with a current patient or client (97.1%). Participants working in geriatric nursing were the least likely to report that they had never done so (63.8%). The participants currently working in forensic nursing were the most likely to report that they had never developed a friendship with a patient or client following discharge (95.9%), participated in recreational or social activities outside of work with a patient or client following discharge (95.9%), invited a current patient or client to their home (100%), or invited a patient or client to their home following discharge (98%). The participants currently working in group therapy (100%) and forensic nursing (98%) were the most likely to report that they had never participated in recreational or social activities outside of work with a current patient or client. Five (1.1%) of the respondents currently working in adult psychiatry and one (1.3%) respondent currently working in child and adolescent mental health reported that they had a sexual relationship with a patient or client following discharge.

As well, there was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in providing assessment and treatment services to friends or family members, developing a friendship with a current patient or client, developing a friendship with a patient or client following discharge, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, inviting a current patient or client to their home, and inviting a patient or client to their home following discharge based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 77 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on current work area.

Table 77

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Current Work Area

Source	df	F Current Work Area	Sig.
Provided Care to Friends or Family			
Between groups	6	3.001	0.006*
Within groups	884		
Commented on a Patient's Physical Attractiveness			
Between groups	6	1.740	0.109
Within groups	885		
Developed a Friendship with a Current Patient			
Between groups	6	5.912	0.000*
Within groups	887		
Developed a Friendship with a Discharged Patient			
Between groups	6	3.512	0.002**
Within groups	887		
Socialized with a Patient Outside of Work			
Between groups	6	5.346	0.000**
Within groups	887		
Socialized with a Discharged Patient			
Between groups	6	5.619	0.000*
Within groups	886		

(table continues)

Source	df	F Current Work Area	Sig.
Invited a Current Patient to your Home			
Between groups	6	3.741	0.001*
Within groups	888		
Invited a Discharged Patient to your Home			
Between groups	6	2.416	0.025*
Within groups	889		
Dated a Current Patient			
Between groups	6	0.923	0.478
Within groups	889		
Dated a Discharged Patient			
Between groups	6	0.412	0.871
Within groups	889		
Had a Sexual Relationship with a Current Patient			
Between groups	6	.	.
Within groups	889		
Had a Sexual Relationship with a Discharged Patient			
Between groups	6	0.670	0.674
Within groups	889		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *workplace location* of the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation indicated that the respondents who worked in a city over 500,000 were the most likely to report that they had never participated in recreational or social activities outside of work with a current patient or client (93.1%). Participants working in a rural area were the least likely to report that they had never done so (65.4%). When asked if they had ever participated in recreational or social activities outside of work with a patient or client following discharge, the respondents working in a city over 500,000 were the most likely to report that they had never done so (87.7%). Participants working in a town were the least likely to report that they had never participated in recreational or social activities outside of work with a patient or client following discharge (68.8%). Two (0.4%) of the respondents who reported that they worked in a city of over 500,000 and 4 (2.8%) of the respondents who worked in a city of under 500,000 reported that they had a sexual relationship with a patient or client following discharge.

As well, there was a significant difference, as shown in the ANOVA, in the behaviours of the respondents developing a friendship with a current patient or client, developing a friendship with a patient or client following discharge, participating in recreational or social activities outside of work with a current patient or client, participating in recreational or social activities outside of work with a patient or client following discharge, inviting a current patient or client to their home, inviting a patient or client to their home following discharge, dating a patient or client following discharge, and having a sexual relationship with a patient or client following discharge based on workplace location. Therefore, the null hypothesis that the respondents, regardless of workplace location, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 78 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on workplace location.

Table 78

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Workplace Location

Source	df	F Workplace Location	Sig.
Provided Care to Friends or Family			
Between groups	4	1.214	0.303
Within groups	863		
Commented on a Patient's Physical Attractiveness			
Between groups	4	0.633	0.639
Within groups	865		
Developed a Friendship with a Current Patient			
Between groups	4	7.345	0.000*
Within groups	866		
Developed a Friendship with a Discharged Patient			
Between groups	4	8.637	0.000*
Within groups	867		
Socialized with a Patient Outside of Work			
Between groups	4	15.064	0.000*
Within groups	865		
Socialized with a Discharged Patient			
Between groups	4	13.520	0.000*
Within groups	865		
Invited a Current Patient to your Home			
Between groups	4	15.321	0.000*
Within groups	867		

(table continues)

Source	df	F Workplace Location	Sig.
Invited a Discharged Patient to your Home			
Between groups	4	5.974	0.000*
Within groups	868		
Dated a Current Patient			
Between groups	4	1.267	0.281
Within groups	868		
Dated a Discharged Patient			
Between groups	4	4.470	0.001*
Within groups	868		
Had a Sexual Relationship with a Current Patient			
Between groups	4	.	.
Within groups	868		
Had a Sexual Relationship with a Discharged Patient			
Between groups	4	3.068	0.016*
Within groups	868		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *amount of time worked* by the respondents and their behaviours toward dual relationships and sexual misconduct when interacting with patients and clients. The cross tabulation results indicated that the nurses working full time were more likely to report that they had never commented to patients or clients on their physical attractiveness (40.0%) than were the respondents working part time (31.3%) or more than full time (17.7%). Two (0.6%) of the respondents who worked part time and 4 (0.8%) of the participants who worked full time reported that they had a sexual relationship with a patient or client following discharge.

As well, there was a significant difference, as shown in the ANOVA, in the behaviours of the respondents in commenting to patients or clients on their physical attractiveness based on the amount of time worked. Therefore, the null hypothesis that the respondents, regardless of amount of time worked, have similar behaviours around dual relationships and sexual misconduct was rejected. Table 79 illustrates the comparison of the behaviours around dual relationships and sexual misconduct reported by the respondents based on amount of time worked.

Table 79

Analysis of Variance of Behaviours Around Dual Relationships and Sexual Misconduct by Amount of Time Worked

		F	
Source	**df**	**Amt. of Time Worked**	**Sig.**
Provided Care to Friends or Family			
Between groups	2	0.015	0.985
Within groups	875		
Commented on a Patient's Physical Attractiveness			
Between groups	2	5.355	0.005*
Within groups	878		
Developed a Friendship with a Current Patient			
Between groups	2	1.075	0.342
Within groups	878		

(table continues)

		F	
Source	**df**	**Amt. of Time Worked**	**Sig.**
Developed a Friendship with a Discharged Patient			
Between groups	2	1.746	0.175
Within groups	878		
Socialized with a Patient Outside of Work			
Between groups	2	2.026	0.132
Within groups	877		
Socialized with a Discharged Patient			
Between groups	2	1.990	0.137
Within groups	877		
Invited a Current Patient to your Home			
Between groups	2	2.096	0.124
Within groups	879		
Invited a Discharged Patient to your Home			
Between groups	2	1.039	0.354
Within groups	880		
Dated a Current Patient			
Between groups	2	0.441	0.644
Within groups	880		
Dated a Discharged Patient			
Between groups	2	0.332	0.718
Within groups	880		
Had a Sexual Relationship with a Current Patient			
Between groups	2	.	.
Within groups	880		
Had a Sexual Relationship with a Discharged Patient			
Between groups	2	0.452	0.637
Within groups	880		

Note. $^{*}p < 0.05$

In summary, in an examination of the attitudes toward dual relationships and sexual misconduct, the null hypotheses that all mental health nurses, regardless of (a) age, (b) marital status, and (c) years of experience, have similar attitudes toward dual relationships and sexual misconduct were accepted. The null hypotheses that all mental health nurses, regardless of (a) gender, (b) nursing education, (c) specialty area, d) current work area, (e) workplace location, and (f) amount of time worked, have similar attitudes toward dual relationships and sexual misconduct were rejected. As well, after an examination of the behaviour around dual relationships and sexual misconduct, none of the null hypotheses were accepted. All of the null hypotheses that all mental health nurses, regardless of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) specialty area, (g) current work area, (h) workplace location, and (i) amount of time worked, have similar behaviours around dual relationships and sexual misconduct were rejected.

Nurse-Patient Relationships

A modified version of Pilette et al.'s (1995) 12-item Nursing Boundary Index was utilized in this section. The respondents were asked to describe the frequency of their attitudes and behaviours around nurse-patient relationships while providing patient care. The participants were asked if they had ever felt that (a) they were the only one who understood a certain patient or client, (b) certain staff members were too critical of one of their patients or clients, and (c) other staff members were jealous of their relationship with a certain patient or client. They were also asked if they had ever (a) arrived early or stayed late to be with one of their patient or clients for a longer period of time, (b) received feedback that they were too involved with patients or clients, (c) acted on sexual feelings that they had for a patient or client, and (d) had sex with a patient or client. The relationship between the independent variables of (a) age, (b) gender, (c) marital status, (d) nursing education, (e) years of experience, (f) area of specialty, (g) current work area, (h) workplace location, and (i) amount of time worked and the dependent variables concerning the attitudes and behaviours around patient care were determined by cross tabulations. Probability values were generated using a one-way analysis of variance statistic. Relationships associated with $p < 0.05$ were considered significant.

The vast majority of the participants reported that they had never acted on sexual feelings toward a patient or client (98.3%), and none of the respondents reported that they had sex with a patient or client (99.3%). The majority of the participants had also never received feedback that they were too involved with a patient or client (81.0%) or that certain staff members were jealous of their relationship with patients or clients (73.6%). As well, 48.2% had never arrived early or stayed late to be with a patient or client, and 40.2% had never felt that they were the only one who understood the patient or client. Surprisingly, only 10.9% had never felt that certain staff members were too critical of one of their patients or clients. Table 80 shows the respondents' reported behaviours around nurse-patient relationships while providing patient care.

Table 80

Attitudes and Behaviours Around Nurse-Patient Relationships

Rating of Frequency	Frequency	Percentage
Only One to Understand a Patient		
Never	371	40.2
Rarely	393	42.6
Sometimes	148	16.0
Often	6	0.7
Always	0	0
No response	5	0.5
Staff Too Critical of your Patient		
Never	101	10.9
Rarely	326	35.3
Sometimes	454	49.3
Often	37	4.0
Always	0	0
No response	4	0.4
Staff Jealous of Relationship with Patient		
Never	679	73.6
Rarely	189	20.5
Sometimes	48	5.2
Often	2	0.2
Always	0	0
No response	5	0.5
Arrived Early and/or Stayed Late to be with a Patient		
Never	445	48.2
Rarely	309	33.5
Sometimes	147	15.9
Often	13	1.4
Always	0	0
No response	9	1.0

(table continues)

Rating of Frequency	Frequency	Percentage
Feedback of Too Involved with a Patient		
Never	748	81.0
Rarely	148	16.0
Sometimes	22	2.4
Often	0	0
Always	0	0
No response	5	0.5
Acted on Sexual Feelings with a Patient		
Never	907	98.3
Rarely	7	0.8
Sometimes	0	0
Often	0	0
Always	0	0
No response	9	1.0
Had Sex with a Patient		
Never	917	99.3
Rarely	0	0
Sometimes	0	0
Often	0	0
Always	0	0
No response	6	0.7

Note. Frequencies may not add up to 923 (total n) and percentages may not add up to100% due to nonresponses for specific variables.

Attitudes and Behaviours Around Nurse-Patient Relationships

The data were examined to determine if there was a significant relationship between the respondents' *age* and their attitudes and behaviours around nurse-patient relationships. The cross tabulations indicated that those nurses aged 31 to 40 were the most likely to report that they never received feedback that they were too involved with a patient or client (89.2%), whereas the nurses aged 51 to 60 were the least likely to report that they had never received such feedback (76.1%). There was also a significant difference, as shown in the

ANOVA, in the attitudes and behaviours around the nurse-patient relationships of the respondents when asked how often they had received feedback that they were too involved with a patient or client based on the age of the mental health nurse. Therefore, the null hypothesis that the respondents, regardless of age, have similar attitudes and behaviours around nurse-patient relationships was rejected. Table 81 indicates the comparison of the respondents' attitudes and behaviours toward nurse-patient relationships based on age.

Table 81

Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Age

Source	df	F Age	Sig.
Only One to Understand a Patient			
Between groups	4	1.916	0.106
Within groups	894		
Staff Too Critical of your Patient			
Between groups	4	1.877	0.112
Within groups	895		
Staff Jealous of Relationship with Patient			
Between groups	4	0.855	0.491
Within groups	894		
Arrived Early and/or Stayed Late to be with a Patient			
Between groups	4	1.896	0.109
Within groups	890		
Staff Feedback of Too Involved with a Patient			
Between groups	4	4.618	0.001*
Within groups	894		

(table continues)

		F	
Source	df	Age	Sig.
Acted on Sexual Feelings with a Patient			
Between groups	4	0.412	0.800
Within groups	890		
Had Sex with a Patient			
Between groups	4	.	.
Within groups	893		

Note. $^{*}p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *gender* and their attitudes and behaviours around nurse-patient relationships. There was a significant difference, as shown in the ANOVA, in the attitudes and behaviours around the nurse-patient relationships of the respondents when asked how often they had received feedback that they got too involved with patients or clients based on gender. Therefore, the null hypothesis that the respondents, regardless of gender, have similar attitudes and behaviours around nurse-patient relationships was rejected. Table 82 indicates the comparison of the attitudes and behaviours toward nurse-patient relationships reported by the mental health nurse based on gender.

Table 82

Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Gender

Source	df	F Gender	Sig.
Only One to Understand a Patient			
Between groups	1	0.1.403	0.237
Within groups	909		
Staff Too Critical of your Patient			
Between groups	1	1.067	0.302
Within groups	910		
Staff Jealous of Relationship with Patient			
Between groups	1	3.960	0.047*
Within groups	909		
Arrived Early and/or Stayed Late to be with a Patient			
Between groups	1	O.291	0.590
Within groups	905		
Staff Feedback of Too Involved with a Patient			
Between groups	1	3.070	0.080
Within groups	909		
Acted on Sexual Feelings with a Patient			
Between groups	1	0.850	0.357
Within groups	905		
Had Sex with a Patient			
Between groups	1	.	.
Within groups	908		

Note. $^*p < 0.05$.

The data were examined to determine if there was a significant relationship between the *marital status* of the respondents and their attitudes and behaviours around nurse-patient relationships. No significant relationship was found in the ANOVA. Therefore, the null hypothesis that the respondents, regardless of marital status, have similar attitudes and behaviours around nurse-patient relationships was accepted.

The data were examined to determine if there was a significant relationship between the respondents' *nursing education* and their attitudes and behaviours around nurse-patient relationships. The cross tabulations indicated that those nurses with an RN diploma were the most likely to report that they had never arrived early or stayed late to be with a patient or client for a longer period of time (51.7%), whereas those nurses with a master's in nursing were the least likely to report that they had never done so (13.0%). These findings should be interpreted with caution, because only 23 nurses reported that they had attained a master's in nursing. There was also a significant difference, as shown in the ANOVA, in the attitudes and behaviours around the nurse-patient relationships of the respondents when asked how often they had arrived early or stayed late to be with a patient or client for a longer period of time based on nursing education. Therefore, the null hypothesis that the respondents, regardless of nursing education, have similar attitudes and behaviours around nurse-patient relationships was rejected. Table 83 indicates the comparison of the attitudes and behaviours toward nurse-patient relationships reported by the mental health nurse based on nursing education.

Table 83

Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Nursing Education

Source	df	F Nursing Education	Sig.
Only One to Understand a Patient			
Between groups	5	0.837	0.523
Within groups	906		
Staff Too Critical of your Patient			
Between groups	5	1.384	0.228
Within groups	907		
Staff Jealous of Relationship with Patient			
Between groups	5	0.995	0.420
Within groups	906		
Arrived Early and/or Stayed Late to be with a Patient			
Between groups	5	4.600	0.000**
Within groups	902		
Staff Feedback of Too Involved with a Patient			
Between groups	5	0.906	0.476
Within groups	906		
Acted on Sexual Feelings with a Patient			
Between groups	5	0.082	0.995
Within groups	902		
Had Sex with a Patient			
Between groups	5	.	.
Within groups	905		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *years of experience* and their attitudes and behaviours around nurse-patient relationships. There was a significant difference, as shown in the ANOVA, in the attitudes and behaviours around the nurse-patient relationships of the respondents when asked how often they had received feedback that they were too involved with a patient or client based on years of experience. Therefore, the null hypothesis that the respondents, regardless of years of experience, have similar attitudes and behaviours around nurse-patient relationships was rejected. Table 84 indicates the comparison of the attitudes and behaviours toward nurse-patient relationships reported by the mental health nurse based on years of experience.

Table 84

Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Years of Experience

		F	
Source	**df**	**Years of Experience**	**Sig.**
Only One to Understand a Patient			
Between groups	4	0.875	0.478
Within groups	889		
Staff Too Critical of your Patient			
Between groups	4	0.963	0.427
Within groups	890		

(table continues)

		F	
Source	df	Years of Experience	Sig.
Staff Jealous of Relationship with Patient			
Between groups	4	1.169	0.323
Within groups	889		
Arrived Early and/or Stayed Late to be with a Patient			
Between groups	4	0.732	0.570
Within groups	886		
Staff Feedback of Too Involved with a Patient			
Between groups	4	5.645	0.000**
Within groups	890		
Acted on Sexual Feelings with a Patient			
Between groups	4	0.448	0.774
Within groups	886		
Had Sex with a Patient			
Between groups	4	.	.
Within groups	889		

Note. *p < 0.05.

The data were examined to determine if there was a significant relationship between the respondents' *specialty area* and their attitudes and behaviours around nurse-patient relationships. The cross tabulations indicated that the nurses specializing in group therapy (48.7%) and forensic nursing (47.6%) were the most likely to report that they had never felt that they were the only ones who understood a certain patient or client, whereas those nurses specializing in child and adolescent mental health were the least likely to report that they had never done so (28.8%). The participants specializing in forensic nursing were the most likely to report that they had never arrived early or stayed late to be with a patient or client for a longer period of time (59.5%), whereas those nurses specializing in child and adolescent mental health were the least likely to report that they had never done so (38.4%).

There was also a significant difference, as shown in the ANOVA, in the attitudes and behaviours around the nurse-patient relationships of the respondents when asked how often they had felt that they were the only ones who understood a certain patient or client and arrived early or stayed late to be with a patient or client for a longer period of time based on specialty area. Therefore, the null hypothesis that the respondents, regardless of specialty area, have similar attitudes and behaviours around nurse-patient relationships was rejected. Table 85 indicates the comparison of the participants' attitudes and behaviours toward nurse-patient relationships based on specialty area.

Table 85

Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Specialty Area

		F	
Source	**df**	**Specialty Area**	**Sig.**
Only One to Understand a Patient			
Between groups	6	2.798	0.011*
Within groups	874		
Staff Too Critical of your Patient			
Between groups	6	1.359	0.228
Within groups	875		
Staff Jealous of Relationship with Patient			
Between groups	6	0.890	0.501
Within groups	875		

(table continues)

		F	
Source	df	Specialty Area	Sig.
Arrived Early and/or Stayed Late to be with a Patient			
Between groups	6	4.352	0.000*
Within groups	872		
Staff Feedback of Too Involved with a Patient			
Between groups	6	1.116	0.351
Within groups	875		
Acted on Sexual Feelings with a Patient			
Between groups	6	1.621	0.138
Within groups	872		
Had Sex with a Patient			
Between groups	6	.	.
Within groups	875		

Note. $^{*}p < 0.05$.

The data were examined to determine if there was a significant relationship between the respondents' *current work area* and their attitudes and behaviours around nurse-patient relationships. The cross tabulations indicated that the nurses currently working in group therapy were the most likely to report that they had never felt that they were the only ones who understood a certain patient or client (47.1%), whereas those nurses currently working in child and adolescent mental health were the least likely to report that they had never done so (27.0%). The participants currently working in forensic nursing were the most likely to report that they had never arrived early or stayed late to be with a patient or client for a longer period of time (61.2%), whereas those participants not currently working in nursing (23.8%) and those working in geriatric nursing

(38.6%) were the least likely to report that they had never done so. These results should be interpreted with caution, because only 21 participants reported that they were not currently working.

There was also a significant difference, as shown in the ANOVA, in the attitudes and behaviours around the nurse-patient relationships of the respondents when asked how often they had felt that they were the only ones who understood a certain patient or client and arrived early or stayed late to be with a patient or client for a longer period of time based on current work area. Therefore, the null hypothesis that the respondents, regardless of current work area, have similar attitudes and behaviours around nurse-patient relationships was rejected. Table 86 indicates the comparison of the attitudes and behaviours toward nurse-patient relationships reported by the mental health nurse based on current work area.

Table 86

Analysis of Variance for Attitudes and Behaviours Around Nurse-Patient Relationships by Current Work Area

Source	**df**	F **Current Work Area**	**Sig.**
Only One to Understand a Patient			
Between groups	6	2.809	0.010*
Within groups	892		
Staff Too Critical of your Patient			
Between groups	6	1.999	0.063
Within groups	893		

(table continues)

Source	df	F Current Work Area	Sig.
Staff Jealous of Relationship with Patient			
Between groups	6	1.139	0.337
Within groups	892		
Arrived Early and/or Stayed Late to be with a Patient			
Between groups	6	4.628	0.000*
Within groups	889		
Staff Feedback of Too Involved with a Patient			
Between groups	6	1.618	0.139
Within groups	893		
Acted on Sexual Feelings with a Patient			
Between groups	6	0.734	0.623
Within groups	889		
Had Sex with a Patient			
Between groups	6	.	.
Within groups	892		

Note. *$p < 0.05$.

The data were examined to determine if there was a significant relationship between the *workplace location* and *amount of time worked* by the respondents, and their attitudes and behaviours around nurse-patient relationships. No significant relationship was found in the ANOVAs. Therefore, the null hypothesis that the respondents, regardless of workplace location and amount of time worked, have similar attitudes and behaviours around nurse-patient relationships was accepted.

In summary, after an examination of the attitudes and behaviours around nurse-patient relationships, the null hypotheses that all mental health nurses, regardless of (a) gender, (b) workplace location, and (c) amount of time worked, have similar attitudes and behaviours around nurse-patient relationships were accepted. The null hypotheses that all mental health nurses, regardless of (a) age, (b) marital status, (c) nursing education, (d) years of experience, (e) specialty area, and (f) current work area, have similar attitudes and behaviours around nurse-patient relationships were rejected.

Summary

Professional Boundary Knowledge

The results of this survey confirmed that the participants placed a high value on the importance of knowledge about professional boundaries. Only one individual indicated that it was not at all important to understand his or her own professional boundaries. The comments obtained in the survey indicated that the participants were aware of the importance of professional boundaries. Examples of some of the comments were, "Glad to see the issue of boundary setting addressed. Frequently have observed younger staff members struggling with this or being unaware behaviour was inappropriate, particularly with the type of patients that we see."

> Nursing, like many professions, has a small number of people who meet their unhealthy needs at the patients' expense, Their lack of personal boundaries, which they present as a willingness "to go the extra mile" does a disservice to the profession. Managers who lack boundaries sometimes expect their frontline workers to follow suit. This can make for a very difficult working environment. Professionalism in nursing sometimes means having to say 'no.'

> I think it is wonderful to have interest paid in this area. I have come across nurses who seem to get the line very blurred. I have also worked with an educator who used the students to meet personal and professional needs without ever realizing the damage being done to the student and the rest of the faculty.

Table 87 provides a summary of the significant ANOVA results for the importance that the participants placed on professional boundary knowledge.

Table 87

Summary of the Significant ANOVA Results for the Importance of Professional Boundary Knowledge

Independent Variable	**Dependent Variable**
Age	Establish professional boundaries with patients
Gender	Understand own professional boundaries Maintain professional boundaries with patients
Marital status	
Nursing education	Understand what professional boundaries are
Years of experience	
Specialty area	Establish professional boundaries with patients Maintain professional boundaries with patients
Current work area	
Workplace location	Establish professional boundaries with patients Maintain professional boundaries with patients
Amount of time worked	Understand what professional boundaries are

Professional Boundary Education

The majority of respondents (79.5%) indicated that they had received some type of education in the area of professional boundaries. When considering the *age*, *specialty area*, *current work area*, and *workplace location* of the participants, it was evident that there was a significant difference in their attainment of professional boundary education. The participants currently working in group therapy (91.2%) and forensic nursing (87.8%) were the most likely to report that they had received some type of professional boundary education, and geriatric nurses (69.0%) were the least likely. Nurses working in a city of over 500,000 (83.3%) were also the most likely to have obtained some type of professional boundary education.

When asked about their method of attaining education about professional boundaries, the respondents indicated that they had received information through the workplace (50.1%), a diploma program (48.9%), or conferences and workshops (40.1%). With the recent increase in interest in professional boundaries, it was expected that younger nurses and more recent graduates would have received more information in their formal education programs. The results of this survey indicated that younger nurses (21 to 30 age group) and those with less experience (0 to 10 years) were more likely to indicate that they had received information in a baccalaureate program. As well, the participants who were prepared at the baccalaureate level were a little more likely to have obtained information regarding professional boundaries through their formal education program than were nurses prepared at the diploma level. Of the 730 nurses (79.2%) graduating with a diploma, only 55.5% of the RNs and 53.6% of the RPNs reported that they had attained information regarding professional boundaries in their educational program. In comparison, 61.9% of the total 293 (16.9%) of respondents prepared at the baccalaureate level reported that they had received education on professional boundaries in their formal education program.

Examples of the comments obtained in the survey regarding the importance of professional boundary education in a formal education program include, "Boundaries were taught in my RPN program. Professionally I am disappointed that they were not taught in my BScN program. Boundaries are important for every nurse whether they work in mental health or not"; and "Not enough importance is paid to personal boundaries at the University level. There should be at least one semester devoted to this subject." Another respondent stated, "Interesting survey, a topic that has been overlooked as an issue and subject in its own right. Especially necessary for new grads. Teaching or coursework in this area should be done in a discussion format."

The importance of professional boundaries in the workplace seems to have been recognized, with 50.1% of the respondents reporting that they had received information through their workplaces. Only 25.3% of the RPNs reported receiving information regarding professional boundaries through the Registered Psychiatric Nurses Association of Alberta. As well, only 28.4% of the RNs in this survey reported receiving information through their professional association. Older nurses and those with more years of experience were more likely to have received their education in professional boundaries through (a) the workplace, (b) conferences and workshops, (c) a professional association, and (d) other ways.

Comments were obtained from the participants regarding the importance of professional boundary education in the workplace, through conferences and workshops, and through professional associations. One participant stated, "More workshops are needed in this area as we become more community focused. Little if anything was taught through my formal education, and I have had to access workshops on my own." Other participants reported that "I think a course on professional boundaries should be mandatory, maybe a standardized one in every workplace"; and "How do we get every nurse to know about the CNA Code of Ethics? Maybe via performance appraisals. Everyone gets a copy of the union contract. Maybe a copy of the Code of Ethics is as important, if not more so."

> Boundaries are very critical to the work that we do in mental health. I believe they are often not understood and not properly monitored. In my experience as a preceptor, I am constantly challenged by the belief that many have re: needing to 'relate personally to be effective professionally'. More emphasis and guidelines are necessary in the work environment. In mental health the compulsory training and re-certifications are in CPR, back injury, and non-violent crisis intervention. Boundaries rank, in my opinion, as a compulsory certification program in this area. It would help to prevent emotional and professional injury to all parties.

> It seems to me that Management (The Health Authority) has abdicated their responsibility to teach more about personal boundaries. Workshops about personal boundaries should be mandatory, the same as CPR and one's Registration. The AARN and RPNAA should have lots of simple articles on their website about personal boundaries. These organizations get involved only when their members are in trouble. They could do more.

Interest in Increasing Professional Boundary Knowledge

Although the participants placed a high value on the importance of knowledge about professional boundaries, only 31.5% reported that they were very interested in increasing their knowledge about professional boundaries. Almost 100 nurses (10.5%) were not at all interested in learning more about professional boundaries. Examples of the participants' comments are listed below:

> I am delighted that you are exploring this topic. Throughout my career I have seen many examples (some with disastrous outcomes) where boundaries have been unclear or have been violated. I think confusion and violations of boundaries are a terrible event for vulnerable mental health clients. More education and clinical supervision are necessary for nurse's practice.
>
> I think professional boundaries are an area often overlooked and I would like to see more education provided to employees regarding this issue. In my place of work there were problems with staff taking patients home, friendships with patients and family members, social activities outside of work, and gift giving. Fortunately, the employer addressed the concerns and attempted to define boundaries. However, the same questions surface over and over again. When staff overstep their boundaries, it divides staff and confuses the patients involved and it can turn units into an uproar.
>
> When I was a young woman, my awareness of myself was much less. Therefore, I needed stricter boundaries with myself and others. I see the workplace where some have become so 'professional' that they come across as 'cold and uncaring' because they are so afraid to cross a professional boundary line. They almost come across as self-righteous and think that their ideas of professional boundaries are the best. These are individual nurses who are trained and have taken extra education in professional boundaries. It's like the issues of professional boundaries are more important that showing human compassion and acceptance of the individual and where they are at in their life's journey. That is why I hesitate to take more education in personal and professional boundaries.

Table 88 provides a summary of the significant ANOVA results for the specific types of professional boundary education reported by the participants.

Table 88

Summary of the Significant ANOVA Results for Specific Types of Professional Boundary Education

Independent Variable	**Dependent Variable**
Age	Baccalaureate program
	Professional association
	Conferences and workshops
Gender	
Marital status	
Nursing education	Baccalaureate program
	Graduate program
	Other
Years of experience	Baccalaureate program
	Graduate program
	Professional association
	Conferences and workshops
Specialty area	Diploma program
	Baccalaureate program
	Graduate program
	Workplace
	Professional association
	Conferences and workshops
	Other
Current work area	Diploma program
	Baccalaureate program
	Graduate program
	Workplace
	Professional association
	Conferences and workshops
	Other

(table continues)

Independent Variable	Dependent Variable
Workplace location	Baccalaureate program Graduate program Workplace Professional association Conferences and workshops Other
Amount of time worked	

Gift-Giving

The participants were asked questions about their gift-giving attitudes and behaviours to assist in determining the norms of gift giving in a mental health setting. The vast majority of respondents felt strongly that it was not appropriate to borrow money from patients or clients (96.9%), accept gifts of over $20.00 from patients or clients (81.4%), or give gifts of over $20.00 to patients or clients (81.7%). Similar to their reported gift-giving attitudes, the respondents indicated that they had never borrowed money from a patient or client (97.6%), accepted gifts of over $20.00 from a patient or client (92.4%), or given a gift of over $20.00 (94.3%).

The participants indicated that they strongly or somewhat agreed that it was appropriate to lend money to patients or clients (8.7%), accept gifts of under $20.00 from patients or clients (13.7%), or give gifts of under $20.00 to patients or clients (11.7%). When reporting their behaviours, the survey participants indicated that, when interacting with patients or clients, they had never lent money (58.8%), accepted gifts of under $20.00 (36.3%), or given gifts of under $20.00 (62.2%).

As stated earlier, Morse (1991b) reported that gifts may be given to nurses by patients as (a) gifts of gratitude to reciprocate for the care given, (b) gifts of obligation for the care given, or (c) gifts intended to manipulate the nursing care or the nurse-patient relationship (Morse 1991b). Examples of the comments obtained in the survey regarding gifts of obligation included, "In some cultures it is considered rude not to accept an offering of appreciation"; "Often families of certain cultures give gifts in the form of money (Chinese New Year), food, etc. To refuse in certain cultures is seen as an insult"; and "I have found with the Italian culture and some other European cultures, that they need to give something, whether it be baking, vegetables etc in appreciation or payment for services."

> I think that some patients get offended if you refuse a gift, especially with some cultures. I encourage them, if they want to give a gift, to give it to all the staff together or to make a donation to the hospital for the other patients who can benefit from their gift. Usually the patients can accept that but will be very offended if you refuse directly without giving a reason.

> In the aboriginal community, gift giving is significant and can be considered appropriate under the right context. Usually a gift would be a 'shared gift' to be used (or valued) by all parties who received the gift. For example, a quilt or blanket given by an aboriginal client to a nurse could be seen as an appropriate gift for 'services rendered.' The blanket would stay with the nursing staff to share or admire together, or be given as a gift to another client deemed to have earned the gift.

The male nurses in this survey were more likely to strongly or somewhat agree that it was appropriate to lend money to patients or clients and were also more likely to report that they sometimes or often lent money to patients or clients. Nurses specializing in group therapy and those currently working in group therapy, child and adolescent mental health, and forensic nursing were the most likely to strongly disagree that it was appropriate to lend money to patients or clients. The participants currently not working or those specializing in other areas and those not currently working were the least likely to report that they strongly disagreed that it was appropriate.

When asked about their behaviours around gift giving, the participants specializing and currently working in forensic nursing were the most likely to report that they had never lent money to patients or clients. Nurses specializing and currently working in adult psychiatry were the least likely to report that they had never done so. Some nurses indicated that they had lent or given small amounts of money to patients in need. Most did not expect to be repaid. Most of the examples below illustrate the nurses' concern and human kindness for the patient or client and included the following: "Sometimes I lend patients bus fare to get home. Often they pay it back when they are able"; "I have 'lent' patients money for the bus or a sandwich but never really expect it back"; "I have lent money to clients so they can do laundry ($2-3)"; "I still discreetly or anonymously lend money to indigent patients"; and "The only time I lent $10, I had my supervisor's okay."

> I had a client whose family in Grande Prairie wanted her home for Christmas. She didn't have money for a bus ticket and her family didn't at the time and asked me to pay for the ticket. They would reimburse me when the mom got paid. I had a really hard time with this as I felt torn in both ways but decided that since it was Christmas and families should be together, etc. etc. I bought her the ticket. She did reimburse me.

Younger nurses, 21 to 30 years of age, and nurses prepared at the baccalaureate and master's level were the most likely to strongly or somewhat agree that it was appropriate to accept gifts of under $20.00 from patients or clients. The participants specializing and currently working in forensic nursing were the most likely to report that they strongly disagreed that it was appropriate to accept gifts of under $20.00 from patients or clients. Nurses specializing in child and adolescent mental health and those currently not working or currently working in child and adolescent mental health were the least likely to report that they strongly disagreed that it was appropriate to accept gifts of under $20.00 from patients or clients.

When asked about their behaviours related to gift giving, the participants specializing in forensic nursing and those currently working in forensic nursing were the most likely to state that they had never accepted gifts of under $20.00 from patients or clients. The participants specializing in child and adolescent mental health and those currently working in child and adolescent mental health were the least likely to report that they had never done so. Some of the participants in this survey indicated the importance that they placed on the acceptance of gifts of gratitude from patients, as evidenced in the following examples: "Sometimes you are faced with a dilemma of offending a client by refusing to accept a gift which is the client's way to thank you for your support. To say no to a gift at Christmas can devastate them and reinforce their loneliness"; and "It is hard to turn away a gift of flowers when you are terminating (last session) with a client and they're showing appreciation for your help."

Nurses prepared at the master's level were the most likely to report that it was appropriate to give gifts of under $20.00 to patients or clients. Nurses prepared at the RPN diploma level, those specializing in forensic nursing and group therapy, and those currently working in forensic and group therapy were the most likely to strongly disagree that it was appropriate to give a gift of under $20.00 to a patient or client. The participants specializing in child and adolescent mental health and those currently working in child and adolescent mental health or currently not working were the least likely to report that they strongly disagreed that it was appropriate to do so.

When asked about their behaviours around gift giving the participants specializing in forensic nursing or group therapy and those currently working in forensic nursing or group therapy were the most likely to state that they had never given gifts of under $20.00 to patient or clients. The participants specializing in child and adolescent mental health and those nurses working in child and adolescent mental health were the least likely to report that they had never done so. Some nurses indicated that they had given small gifts to patients in need. Again, most of the examples of gift giving illustrate the nurses' concern and human kindness for the patient or client and included the following: "Staff on an inpatient unit where I once worked would collect money from staff (voluntary basis) to purchase items such as Christmas presents and toiletries not provided by the hospital"; and "I have given a half deck of cigarettes to clients on admission if they are in need. For planned client outings where the client declines because of no money, I'll give them a dollar or two for coffee. I have never given more than five dollars." Other survey participants wrote, "In our facility, we give gifts anonymously to residents each Christmas" and "We have many 'street people.' We often buy them toothbrushes, razors, the newspaper, etc. that are not provided by the hospital and which they have no money for." Tables 89 and 90 provide a summary of the significant results of the ANOVAs for the participants' gift-giving attitudes and behaviours.

Table 89

Summary of the Significant ANOVA Results for Gift Giving Attitudes

Independent Variable	**Dependent Variable**
Age	Accept gifts of under $20.00
Gender	Lend money to patients or clients Give gifts of over $20.00
Marital status	
Nursing education	Accepting gifts of under $20.00 Give gifts of under $20.00
Years of experience	Lend money to patients or clients
Specialty area	Lend money to patients or clients Accept gifts of under $20.00 Give gifts of under $20.00
Current Work Area	Lend money to patients or clients Accept gifts of under $20.00 Give gifts of under $20.00
Workplace location	Accept gifts of under $20.00
Amount of time worked	

Table 90

Summary of the Significant ANOVA Results for Gift-Giving Behaviours

Independent Variable	Dependent Variable
Age	
Gender	Lent money to patients or clients Accepted gifts of under $20.00
Marital status	
Nursing education	Lent money to patients or clients Accepted gifts of under $20.00 Gave gifts of under $20.00
Years of experience	Lent money to patients or clients Gave gifts of under $20.00
Specialty area	Lent money to patients or clients Accepted gifts of under $20.00 Gave gifts of under $20.00
Current work area	Lent money to patients or clients Accepted gifts of under $20.00 Gave gifts of under $20.00
Workplace location	Lent money to patients or clients Gave gifts of under $20.00
Amount of time worked	Lent money to patients or clients Gave gifts of under $20.00 Gave gifts of over $20.00

Personal Disclosure

The participants' attitudes and behaviours around personal disclosure were surprisingly similar. Most of the mental health nurses in this survey strongly disagreed that it was appropriate to provide their home address (94.6%) or home phone number to patients or clients (88.1%). When reporting their behaviours, they indicated that they had never provided their home address (95.9%) or home phone number to patients or clients (88.5%). The participants also strongly disagreed that it was appropriate to discuss their own mental health issues (79.1%) or discuss their own interpersonal issues (65.9%). The majority of the participants also indicated that they had never discussed their own mental health issues (85.0%) or discussed their own interpersonal issues (64.8%).

When asked about using first names with patients and clients, only 0.9% of the participants reported that they had never done so, and 72.6% strongly agreed that it was appropriate to do so. The cross tabulations indicated that the younger a nurse, the more likely he or she was to strongly agreed that it was appropriate to use first name with patients or clients. The youngest nurses (21 to 20) were also most likely to report that they always used first names with patients or clients. Nurses with the fewest years of experience (0 to 10) were also the most likely to strongly agree that it was appropriate to use first names with patients or clients. Nurses with 11 to 20 years of experience (51.7%) and 0 to 10 years of experience (49.8%) were the most likely to report that they always used first names with patients or clients. The most experienced nurses (41 to 50 years of experience) were the least likely to report that they always used first names with patients or clients.

Nurses specializing and currently working in geriatric nursing were the most likely to report that they strongly disagreed that it was appropriate to use first names with patients or clients. They were also the least likely to report that they always used first names with patients or clients. Nurses specializing and currently working in child and adolescent mental health were the most likely to state that they strongly agreed that it was appropriate to use first names with patients or clients. Participants working in forensic nursing (67.3%) and child and adolescent metal health (65.8%) were the most likely to report that they always used first names with patients and clients.

Some of the survey participants indicated that the use of first names with patients was an accepted practice in their workplaces. "Where I work, we always use first names - staff and patients, including the doctor, program manager, etc"; "As a rule, I only give out my first name and do not provide my last name unless it is absolutely required"; and "I prefer to use last names but feel pressured by doctors and coworkers when they talk about 'Mary' and I don't know who they mean and vice versa." Another nurse stated:

> It is puzzling to me why in section 19, there are questions re: using first names with clients as it is a common belief in my workplace that the use of one's last name with clients is in fact a boundary violation not to mention a safety issue.

Other nurses recognized the need to enquire as to the patient's preference regarding the use of first names. "Must clarify with the person what they wish and what they would like to be addressed as" and

> The atmosphere in the facility where I work is very informal, thus everyone, clients and staff, are addressed by first names. I generally prefer to ask the clients what they prefer to be called. In most cases, they say by their first names.

Surprisingly, only 35.0% of the mental health nurses felt strongly that it was inappropriate to discuss their religious beliefs with patients or clients, and 43.3% reported that they had never done so. One nurse wrote "I have never discussed or felt the need to discuss my own personal religious beliefs with clients. However, I cannot be certain that a time might come when cautious partial disclosure might have a place." Another nurse wrote, "I do discuss my religious beliefs but in a manner providing comfort, e.g. I may say to a grieving or despondent patient that I have found prayer effective, if you need help, I can refer you to a pastor."

The participants also strongly disagreed that it was appropriate to curse or swear (72.5%) during interactions with patients or clients, and most reported that they had never done so (64.2%). Younger nurses, those in the 21 to 30 age group (65.4%) and the 31 to 40 age group (62.5%), were the least likely to strongly disagree that it was appropriate to curse or swear when interacting with patients or clients. The participants working in geriatric nursing were the most likely to report that they strongly disagreed that it was appropriate to curse or swear, and they were also the most likely to report that they had never cursed or sworn when interacting with patients or clients. The nurses working in group therapy and forensic nursing were the least likely to strongly disagree that it was appropriate to curse or swear and were also the least likely to report that they had never cursed or sworn. One nurse commented on his or her use of swearing when interacting with patients:

> Re: Using swearing during conversations. I think I probably have when talking with an adolescent as it is often easier to engage them if you use their "language." I might say "ass" as in "you might have to kiss their ass if you want to live there, . . ." but it's usually in response to what they have already said, i.e. "I won't kiss their ass."

Other comments included the following: "Discussed my own interpersonal issues - Shared experience of loss of a loved one. Discussed my own mental health issues - They got bored and fell asleep - no use."

> I don't believe that you can expect a patient to trust and disclose all of themselves with nothing in return. I have no problem discussing some personal information (what movies or books I like, hobbies, etc.) though I would never disclose more personal information (relationships etc.).

> I want to believe that my self-disclosure and other boundary crossing areas are used therapeutically only, and not ever in a way that gratifies me personally in any way. This is something I would like to look at more closely now that this survey has made me think about my actions and motivations.

> Nurses who are experienced and skilled can bend (or cross) boundaries for a particular goal. They function at the 'expert' level of critical thinking, rather than the concrete level of knowing 'the rule'. May of us were taught that self-disclosure is never appropriate, but selective use of self-disclosure can be very effective in some cases.

Tables 91 and 92 provide a summary of the significant ANOVA results for the participants' attitudes and behaviours toward personal disclosure.

Table 91

Summary of the Significant ANOVA Results for Attitudes Toward Personal Disclosure

Independent Variable	Dependent Variable
Age	Use first names with patients or clients Discuss own religious beliefs Discuss own interpersonal issues Discuss own mental health issues Curse or swear
Gender	Discuss own mental health issues Curse or swear Provide their home phone number
Marital status	
Nursing education	Discuss own religious beliefs Curse or swear Provide their home phone number Provide their home address
Years of experience	Use first names with patients or clients Discuss own religious beliefs
Specialty area	Use first names with patients or clients Discuss own religious beliefs Curing or swearing
Current work area	Using first names with patients or clients Discussing own religious beliefs Cursing or swearing Providing their home phone number
Workplace location	Providing their home phone number Providing their home address
Amount of time worked	Discussing own religious beliefs Providing their home phone number

Table 92

Summary of the Significant ANOVA Results for Behaviours Around Personal Disclosure

Independent Variable	Dependent Variable
Age	Used first names with patients or clients Cursed or sworn Provided their home phone number
Gender	Discussed own religious beliefs Cursed or sworn
Marital status	
Nursing education	Discussed own interpersonal issues Cursed or sworn Provided their home phone number Provided their home address
Years of experience	Cursed or sworn
Specialty area	Used first names with patients or clients Cursed or sworn Provided their home phone number
Current work area	Used first names with patients or clients Cursed or sworn Provided their home phone number
Workplace location	Provided their home phone number Provided their home address
Amount of time worked	Discussed own religious beliefs Provided their home phone number

Confidentiality and Secrecy

The majority of participants reported that they strongly disagreed that it was appropriate to ask a patient or client to keep a confidence from the treatment team (90.0%), keep a confidence regarding the safety of the patient or client from the treatment team at the request of the patient or client (92.7%), or keep a confidence regarding the safety of others in the patients or client's life from the treatment team at the request of a patient or client (89.6%). Similarly, the majority of participants stated that they had never asked a patient or client to keep a confidence from the treatment team (95.6%), kept a confidence regarding the safety of the patient or client from the treatment team at the request of the patient or client (94.4%), or kept a confidence regarding the safety of others in the patients or client's life from the treatment team at the request of a patient or client (91.8%).

Fewer of the participants reported that they strongly disagreed that it was appropriate to keep a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client (53.3%) or keep a confidence regarding the patient or client from the treatment team at the request of a patient or client (61.2%). Similarly, the participants reported that they had never kept a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client (65.3%) or kept a confidence regarding the patient or client from the treatment team at the request of a patient or client (70.4%).

The participants specializing in group therapy were the most likely to strongly disagree that it was appropriate to keep a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client (69.2%), whereas those who reported that they had no specialty area were the least likely to strongly disagree (40.0%). The participants currently working in forensic nursing were also the most likely to strongly disagree that it was appropriate to keep a confidence regarding others in the patient or client's life from the treatment team at the request of the patient or client (75.5%), whereas those who reported that they had no specialty area were the least likely (42.9%) to strongly disagree.

The participants specializing in forensic nursing were the most likely to strongly disagree that it was appropriate to keep a confidence regarding a patient or client from the treatment team at the request of the patient or client (73.8%), whereas those specializing in child and adolescent mental health were the least likely to strongly disagree (50.7%). The participants currently working in forensic nursing were, again, the most likely to strongly disagree that it was appropriate to keep a confidence regarding the patient or client from the treatment team at the request of the patient or client (79.6%), with those currently working in other areas of nursing (53.7%) and those working in child and adolescent mental health (53.9%) the least likely to strongly disagree. When behaviours around confidentiality and secrecy were examined, it was evident that nurses currently working in group therapy were the most likely to report that they had never kept a confidence regarding the patient or client from the treatment team at the request of the patient or client (81.8%), whereas the nurses who reported that they were not currently working were the least likely to report that they had never kept a confidence regarding the patient or client from the treatment team (47.6%).

Nurses working in a city of over 500,000 were more likely to strongly disagree that it was appropriate to keep a confidence regarding the patient or client from the treatment team at the request of the patient or client (67.0%) than were those nurses working in a city of under 500,000 (54.9%), a town (54.2%), a village or hamlet, (50.0%), or a rural area (53.8%).

The participants working in a city of over 500,000 were also more likely to report that they had never kept a confidence regarding the patient or client from the treatment team at the request of the patient or client (75.9%). Nurses working in a rural area (57.7%) or town (63.4%) were the least likely to report that they had never kept a confidence regarding the patient or client from the treatment team at the request of the patient or client.

The following comments were obtained from the participants: "My patients are always informed that I am part of a team and that being the case, I cannot keep confidential information that they wish to share"; and "Confidentiality is very important. I view the treatment team as one entity, therefore confidentiality is not a consideration from one team member to another."

> If asked by a patient: 'I want to tell you something but you can't tell anyone else,' I decline and state my role and responsibilities. However there are instances when patients have confided information that is peripheral to treatment. These types of privacy issues are observed if it presents no problems.

Tables 93 and 94 provide a summary of the significant ANOVA results for the participants' attitudes and behaviours around confidentiality and secrecy.

Table 93

Summary of the Significant ANOVA Results for Attitudes Toward Confidentiality and Secrecy

Independent Variable	Dependent Variable
Age	Ask a patient to keep a confidences from team
Gender	Ask a patient to keep a confidences from team Keep a confidence regarding patient's safety
Marital status	
Nursing education	Keep a confidence regarding others in pt's. life
Years of experience	
Specialty area	Ask a patient to keep a confidences from team Keep a confidence regarding others in pt's life Keep a patient confidence from treatment team
Current work area	Ask a patient to keep a confidences from team Keep a confidence regarding others in pt's life Keep a patient confidence from treatment team
Workplace location	Keep a patient confidence from treatment team
Amount of time worked	

Table 94

Summary of the Significant ANOVA Results for Behaviours Around Confidentiality and Secrecy

Independent Variable	Dependent Variable
Age	Kept a confidence regarding patient's safety
Gender	Asked a patient to keep a confidences from team
Marital status	
Nursing education	
Years of experience	
Specialty area	
Current work area	Kept a patient's confidence from treatment team
Workplace location	Kept a patient's confidence from treatment team
Amount of time worked	

Personal Space

The majority of mental health nurses (86.8%) reported that they strongly disagreed that it was appropriate to kiss a patient or client, and 90.8% reported that they had never done so. When asked about the appropriateness of the use of therapeutic massage with a patient or client, 34.6% strongly disagreed that it was appropriate, and 57.5% reported that they had never actually used therapeutic massage with a patient or client. Not surprisingly, fewer participants reported that they strongly disagreed that it was appropriate to hold a patient's hand (8.0%), put their arm around a patient or client (9.6%), or hug a patient or client (14.8%). When asked about their behaviours, the participants reported that they had never held a patient or client's hand (11.1%), put their arm around a patient or client (11.5%), or hugged a patient or client (17.4%).

The participants specializing and currently working in forensic nursing were the most likely to strongly disagree that it was appropriate to use therapeutic massage with patients or clients, whereas those nurses specializing or currently working in geriatric nursing were the least likely to strongly disagree. The participants specializing in and currently working in group therapy were the most likely to report that they had never used therapeutic massage with patients or clients, whereas those nurses specializing or currently working in geriatric nursing were the least likely to report that they had never done so.

The participants' comments regarding therapeutic massage included, "Therapeutic massage helps to relax geriatric patients and I prefer to do that rather than give them medications if that helps them," "Geriatric patients can benefit from therapeutic massage if not contraindicated (i.e. back massaged with rubbing alcohol to stimulate blood flow)," and "While I believe that therapeutic massage can be an appropriate nursing intervention, I feel it is generally not appropriate in psychiatric nursing due to the boundary difficulties that many psychiatric patients exhibit."

The age of the patient or client and the type of patients in the current work area appeared to be a factor that was considered by the participants. The participants working in geriatric nursing were the most likely to report that it was appropriate to hold a patient or clients' hand, put their arm around a patient or client, or hug or kiss a patient or client. Female respondents were more likely to strongly agree that it was appropriate to hold a patient or client's hand. Participants working in group therapy were the least likely to report that it was appropriate to hold a patient or clients' hand. Participants working in forensic nursing were the most likely to strongly disagree that it was appropriate to put their arm around a patient or client, or hug or kiss a patient or client.

When the nurse's behaviours were examined, the participants specializing and currently working in geriatric nursing were the least likely to report that they had never held a patient or clients' hand, put their arm around a patient or client, and hugged or kissed a patient or client. Nurses specializing in group therapy were the most likely to report that they had never held a patient or client's hand. Participants specializing in forensic nursing were the most likely to report that they had never put their arm around a patient or client, hugged, or kissed a patient or client. Participants working in forensic nursing were the most likely to report that they had never held a patient or clients' hand, put their arm around a patient or client, and hugged a patient or client. Nurses currently working in group therapy (100%), forensic (98.0%) and adult (96.1%) were the most likely to report that they had never kissed a patient or client.

The comments of the participants regarding the use of personal touch with children and adolescents included: "Boundaries differ when you look at the population I work with, i.e. Age 4 to 14. Using our first names is common, plus hugs, high fives, arm over shoulders" and "I have worked with children in a hospital setting as a staff nurse. As a result we have, for example, held a child's hand as they cross the street."

> When answering the questions regarding personal space, many of my responses were in relation to my experience with children, who at times, have come running to me for a hello hug at the beginning of a session. It is very appropriate, for example, to hold a five year olds hand when you walk down a hall, but not for teens.

Many of the participants commented on the use of personal touch with the geriatric population, including, "It may be appropriate to hold the hand of an elderly patient with dementia; the same gesture might be inappropriate on an acute admission ward with young males and females" and

> I work with geriatric clients so I do things differently than I would with a client my own age. I would hug my 86 year old client when she's crying or hold her hand if she's agitated but I doubt I would if she were 36 years old.

The following comments were also received: "Never would I have showed physical affection in a Forensic setting. However, I find in geriatrics, physical contact is very comforting to the elderly especially when they are very ill or dying."

> Older people do crave the human touch (not in a sexual way). I believe physical touch, hand holding, and hugging to be important to some geriatric clients. It conveys a level of mutual acceptance and is perceived as acting on caring.

> Working with psycho-geriatric patients is very different from acute psychiatry. Staff are often the 'families' to some of these patients, especially the long-term psychiatric patients who are now geriatric. Physical contact is often reassuring to these folks and therefore appropriate behaviour.

> I strongly believe that professional boundaries need to be looked at in context to one's area of work. Having worked primarily with geriatrics, I feel it is ok to give hugs and hold hands with certain geriatric patients. Yet, I would not think it was ok to do the same in adult psychiatry or brain injury.

> Please note that in providing physical care to a geriatric population the professional boundaries are not as clearly defined as with an adult population. For many geriatric patients touch is a reassuring communication. I have often sat at the bedside of a palliative patient and quietly held a hand or stroked a brow to help them know that they were not alone. This would be inappropriate in an adult population and could easily be misunderstood.

> I work in a long-term care facility with a geriatric population. As a result I believe that hugs and kisses on the cheek or forehead are appropriate with some clients, this is very individual, some clients need this closeness, others don't want it.

> I believe it is appropriate at rare times to give a friendly kiss to a same-sex patient, particularly in the area of geriatrics. I also believe that, at times, over-concern about professional boundaries deprives our patients of the common comforting human touch. How sad!

The participants also described specific nursing situations where they had used personal touch: "I've hugged very depressed and distraught depressed female patients what want a hug. I often put my hand on their hand or pat them on their backs."

> I would never hold a patient's hand to show affection but would do so to convey comfort and support, i.e. a frightened patient about to have ECT. As well, I would feel more comfortable showing some degree of affection toward a female or elderly patient, whereas I wouldn't feel comfortable with a middle aged male.

> I find touch to be a very powerful therapeutic tool. Although, while I do use this when appropriate, I find that I use it with women rather than men, to avoid misinterpretation of the touch. It is my experience that women use touch in their communication.

Tables 95 and 96 provide a summary for the significant ANOVA results for the participants' attitudes and behaviours toward personal space.

Table 95

Summary of the Significant ANOVA Results for Personal Space Attitudes

Independent Variable	Dependent Variable
Age	Hold a patient or client's hand Put their arm around a patient or client
Gender	Hold a patient or client's hand
Marital status	
Nursing education	
Years of experience	Use therapeutic massage Hold a patient or client's hand Put their arm around a patient or client Hug a patient or client
Specialty area	Use therapeutic massage Hold a patient or client's hand Put their arm around a patient or client Hug a patient or client Kiss a patient or client
Current work area	Use therapeutic massage Hold a patient or client's hand Put their arm around a patient or client Hug a patient or client Kiss a patient or client
Workplace location	Put their arm around a patient or client Hug a patient or client Kiss a patient or client
Amount of time worked	Hold a patient or client's hand Put their arm around a patient or client Hug a patient or client

Table 96

Summary of the Significant ANOVA Results for Personal Space Behaviours

Independent Variable	Dependent Variable
Age	
Gender	
Marital status	
Nursing education	Kissed a patient
Years of experience	
Specialty area	Used therapeutic massage Held a patient or client's hand Put their arm around a patient or client Hugged a patient or client Kissed a patient or client
Current work area	Used therapeutic massage Held a patient or client's hand Put their arm around a patient or client Hugged a patient or client Kissed a patient or client
Workplace location	Used therapeutic massage Held a patient or client's hand Put their arm around a patient or client Hugged a patient or client Kissed a patient or client
Amount of time worked	

Dual Relationships and Sexual Misconduct

The vast majority of respondents strongly disagreed that it was appropriate to invite a current patient or client to their home (90.2%), go on a date with a current patient or client (98.9%), or have a sexual relationship with a current patient or client (99.3%). When reporting their behaviours around dual relationships and sexual misconduct, the vast majority also indicated that they had never invited a current patient or client to their home (93.4%), gone on a date with a current patient or client (98.8%), or had a sexual relationship with a current patient or client (98.9%). Ten respondents (1.1%) did not answer the question about participating in a sexual relationship with a current patient or client.

The participants also reported that they strongly disagreed that it was appropriate, following discharge, to invite a patient or client to their home (81.9%), go on a date with a patient or client (91.9%), or to have a sexual relationship with a patient or client (94.0%). When reporting their behaviours, the participants also indicated that they had never, following discharge, invited a patient or client to their home (92.0%), gone on a date with a patient or client (97.9%), or had a sexual relationship with a patient or client (98.3%).

When asked about their attitudes toward dual relationships the participants specializing in geriatric nursing were the most likely to strongly agree that it was appropriate to provide assessment and treatment services to friends or family members, whereas nurses working in child and adolescent mental health were the least likely. When asked about their behaviours around dual relationships, nurses specializing in group therapy were the most likely to report that they had never provided assessment and treatment services to friends or family members, whereas nurses who indicated that they had no specialty area were the least likely to report that they had never done so. One participant's comment regarding the appropriateness of providing assessment and treatment services to family and friends was, "Involvement, as a professional, in the treatment of a loved one, a colleague, or friend is not appropriate."

Male nurses and those who worked full-time were the most likely to report that they strongly disagreed that it was appropriate to comment to patients or clients on their physical attractiveness. Male nurses and those who worked full-time were also the most likely to report that they had never commented to patients or clients on their physical attractiveness. The participants reported that they generally commented on physical attractiveness to improve a patient's self-esteem and not to make sexual remarks. Examples of the participants comments include, "Commenting on physical appearance is appropriate when self esteem issues are involved or when improvements in personal care warrant noting"; "A client who has made effort in regards to cleanliness, dress and make up, deserves comment or encouragement"; and "There are times it is important to comment on client's 'good points' including physical appearance to promote self-esteem." Other examples included, "Have told clients they look very nice today. No sexual connotations meant."

> This is a bit misleading as someone could say, "You have a lot going for you, you are smart, pretty, etc.: in conversation during an interaction when you are reassuring a patient of their positive attributes. This is *very* different from an inappropriate sexual comment.

Female participants, those specializing in group therapy, those currently working in group therapy, and those working in a city of over 500,000 were the most likely to report that they strongly disagreed that it was appropriate to develop a friendship with a current patient or client. The participants specializing in geriatric nursing were the least likely to report that they strongly disagreed that it was appropriate to develop a friendship with a current patient or client.

When asked about their behaviours around dual relationships, younger nurses (21 to 30 years of age), female participants, those specializing in group therapy, and those currently working in group therapy were also the most likely to report that they had never developed a friendship with a current patient or client. The participants specializing in geriatric nursing and those with an RPN diploma or a Bachelor of Science in Mental Health (other) were the least likely to report that they had never developed a friendship with a current patient or client.

The participants' comments regarding the appropriateness of developing a friendship with a patient or client included, "On two occasions I have developed a friendship with a patient. These involved coming to my house to have dinner with my family and one involved becoming a member on my curling team. Both were non-sexual in any sense but did involve friendship outside the work boundaries" and "Especially in mental health nursing the transition from friend to date is 'too easy' an area of treating relationships casually. Looking for personal or sexual gratification in relationships with patients should be an absolute no-no."

> The ability to maintain an objective approach coupled with a respect for and acknowledgement of the humanity of the patient/client is vital to the provision of professional care. The ability to sustain and attain objectivity

> is impaired when there is a close personal relationship with the patient or client and is separate of the professional relationship.
>
> I am concerned when having learned this last year of a friendship that developed between a client at Alberta Mental Health and her therapist. When this client was referred to us for a day program the client had been transferred to a new therapist, however the friendship between the original therapist and client continued with full knowledge by the managers at AMH. The client was given continued "advise and counsel" by the therapist (original) despite the contradiction of same with the client's psychiatrist and actual therapist. We observed a huge detriment to the client and when we and the "actual" therapist made our views of this known to the "managers." All they did was transfer the client to *another* therapist and allowed the "friendship" to continue! We are appalled.

Female participants, those specializing in forensic nursing and those currently working in forensic nursing were the most likely to report that they strongly disagreed that it was appropriate to develop a friendship with a patient or client following discharge, whereas those participants specializing in geriatrics and those not currently working in nursing were the least likely to report that they strongly disagreed. When asked about their behaviours toward dual relationships, younger nurses (21 to 30 years of age) and female nurses were the most likely to report that they had never developed a friendship with a patient or client following discharge. Nurses with an RPN diploma or a Bachelor of Science in mental health were the least likely to report that they had never developed a friendship with a patient or client following discharge.

Younger nurses (21 to 30 years of age), female participants, those with an RN diploma, those specializing in forensic nursing, those currently working in forensic nursing, and those working in a city of over 500.000 were the most likely to report that they strongly disagreed that it was appropriate to participate in recreational or social activities outside of work with a current patient or client. When asked about their attitudes toward dual relationships, the participants working in geriatric nursing and those not currently working in nursing were the least likely to report that they strongly disagreed that it was appropriate to participate in recreational or social activities outside of work with a current patient or client.

Younger nurses (21 to 30 years of age), female participants, those specializing in forensic nursing, those currently working in group therapy and forensic nursing, and those working in a city over 500,000 were also the most likely to report that they had never participated in recreational or social activities outside of work with a current patient or client. When asked about their behaviours toward dual relationships, nurses specializing in child and adolescent mental health and those working in a rural area were the least likely to report that they never participated in recreational or social activities outside of work with a current patient or client. The following comments reflect the participants' views about socializing with patients and clients:

> From a small town perspective, it is sometimes difficult to not socialize to some degree with ex-clients. You know them before the client-nurse relationship began, and you will after discharge. You belong to the same groups and attend the same functions. However the nurse-client line is observed, though not written.

> Sometimes in rural and small towns it might be impossible not to interact with your clients in a non-professional way, in a recreational activity (i.e. curling, bowling, aerobics) as there are only a few activities and by the nature of small towns you will run into clients in your personal life.

> I believe nursing in the northern remote communities makes the situation different. If the nurse does not participate in the community social and recreational activities, trust will never be established with clients or potential clients. The whole community is his or her scope of practice, and mental health becomes non-separable when addressing the health issues of a client.

> I have attended the weddings and funerals of clients when invited, also a 50th birthday party in a restaurant. I was once honoured by an aboriginal family by being asked to be a god parent to a newborn child. Have been invited to aboriginal community celebrations and ceremonies. There are times, when working with aboriginal clients when it would be insulting to refuse certain invitations, nevertheless boundaries are still there.

> I live in a small community. I frequently treat individuals I have known or will know in the future. Our children play on the same sports teams, or attend school together. I would prefer to keep my professional and personal life separate but it's inappropriate to believe that's true in my community. Respect, trust, and confidentiality is most important. In my personal life with former patients, I keep a great distance but am courteous and polite.

> Social and professional boundaries are also affected by geography. I worked community mental health in a northern community and it was impossible to avoid present/past clients in social situations. Clients are at the stores, the recreational activities, and the bars. You may be invited to a house party and find several clients there. I have invited people to my house and had them bring along a client that had not been invited. In small communities it is easy to have these boundaries crossed unless you totally isolate yourself from all activity. Also clients tend to know your address or place of residence in a small community and think nothing of dropping by for a visit. I found my boundaries being constantly broken and with little support from the managers, it's considered acceptable to have little privacy and Public Relations is more important.

When asked about their attitudes toward dual relationships, the participants with an RN diploma, those specializing in forensic nursing, and those currently working in forensic nursing were the most likely to report that they strongly disagreed that it was appropriate to participate in recreational or social activities outside of work with a patient or client following discharge. Participants specializing in geriatric nursing and those not currently working in nursing were the least likely to report that they strongly disagreed.

When asked about their behaviours toward dual relationships, younger nurses (21 to 30 years of age), female nurses, those specializing in forensic nursing, those currently working in forensic nursing, and those working in a city of over 500,000 were the most likely to report that they had never participated in recreational or social activities outside of work with a patient or client following discharge. Nurses specializing in child and adolescent mental health, those currently working in other areas, and those working in a town were the least likely to report that they had never done so.

Female participants, those with an RN diploma, those specializing in forensic nursing, those currently working in forensic nursing, and those working in a city of over 500,000 were the most likely to report that they strongly disagreed that it was appropriate to invite a current patient or client to their home. Participants specializing in geriatric nursing and those not currently working in nursing were the least likely to report that they strongly disagreed that it was appropriate to invite a current patient or client to their home.

When asked about their behaviours around dual relationships, younger nurses (21 to 30 years of age), female nurses, those who were widowed, and those who specialized in forensic nursing reported that they had never invited a current patient or client to their home. Nurses who reported that they were separated or divorced and those specializing in geriatric nursing and child and adolescent mental health were the least likely to report that they had never invited a current patient or client to their home. Nurses with an RPN diploma or a Bachelor of Science in Mental Health (other) were also the least likely to report that they had never invited a current patient or client to their home.

When asked about their attitudes around dual relationships, younger nurses (21 to 30 years of age), those participants with an RN diploma, those specializing in forensic nursing, those currently working in forensic nursing, and those working in a city of over 500,000 were the most likely to report that they strongly disagreed that it was appropriate to invite a patient or client to their home following discharge. Nurses specializing in geriatric nursing and nurses not currently working in nursing were the least likely to report that they strongly disagreed that it was appropriate to invite a patient or client to their home following discharge.

When asked about their behaviours around dual relationships, those participants who were widowed or living common-law reported that they had never dated a patient or client following discharge. Younger nurses (21 to 30 years of age), female and single participants were the most likely to report that they had never dated a patient or client following discharge. Single and married participants were the most likely to report that they had a sexual relationship with a patient or client following discharge, whereas those participants who were widowed, separated or divorced, or living common-law reported that they had never done so.

When asked about the appropriateness of dating a current or discharged patient or client, four nurses reported that they strongly agreed. Only one nurse reported that he or she had rarely dated a current patient or client, whereas eight nurses reported that they had rarely dated a discharged patient or client, and one nurse reported that he or she sometimes had dated a discharged patient or client.

When asked about their attitudes toward sexual misconduct, four nurses reported that they strongly agreed that it was appropriate to have a sexual relationship with both a current and a discharged patient or client. When the participants were asked if they had a sexual relationship with a current patient or client, no one reported that they had done so. When asked if they had a sexual relationship with a discharged patient, five nurses reported that they had done so rarely, and one nurse stated that he or she had done so sometimes.

Nurses who reported that they had committed the most serious boundary violations of having a sexual relationship with a patient or client following discharge were between the ages of 31 and 60 and were more likely to be male and single and to be prepared at the diploma RPN level. The nurses who reported that they had a sexual relationship with a patient or client following discharge all reported that their specialty area was adult psychiatry, and all were currently working in adult psychiatry, except for one participant who was currently working in child and adolescent mental health. The nurses who reported that they had a sexual relationship with a patient or client following discharge all reported that they worked in a city of over 500,000 or worked in a city of under 500,000. These findings must be interpreted with caution because only six participants reported that they had a sexual relationship with a patient or client following discharge.

Some of the participants' comments regarding sexual misconduct were, "Sexual contact between a nurse and a patient before or after discharge from care is not appropriate"; "I deal exclusively with offenders only. I do know of a nurse that did get sexually involved with an offender (staff nurse). YUCK!!!"; and "On two separate occasions co-staff had 'liaisons' with patients and it had long reaching implications for their patient's future care. Both were subsequently readmitted and it affected the therapeutic relationship with future nurses greatly."

> Once in my twenty-year career in Mental Health, I was very strongly attracted to a patient. I met him once following discharge and had a very brief sexual encounter. We never met again. For years I felt very guilty as this behaviour went against all that I believe to be professional. As a result of the encounter and my feelings surrounding the event, I came to understand a great deal about myself and this self-awareness and self-exploration has helped me in all the years that have followed. Fortunately there were no victims.

Tables 97 and 98 provide a summary of the significant ANOVA results for the participants' attitudes and behaviours around dual relationships and sexual misconduct.

Table 97

Summary of the Significant ANOVA Results for Attitudes Toward Dual Relationships and Sexual Misconduct

Independent Variable	Dependent Variable
Age	
Gender	Develop a friendship with a current patient Develop a friendship with a discharged patient Socialize with a patient outside of work Invite a current patient to their home
Marital status	
Nursing education	Develop a friendship with a current patient Socialize with a current patient outside of work Socialize with a discharged patient outside of work Invite a current patient to their home Invite a discharged patient to their home
Years of experience	
Specialty area	Provide care to family and friends Develop a friendship with a current patient Develop a friendship with a discharged patient Socialize with a current patient outside of work Socialize with a discharged patient outside of work Invite a current patient to their home Invite a discharged patient to their home
Current work area	Provide care to family and friends Develop a friendship with a current patient Develop a friendship with a discharged patient Socialize with a current patient outside of work Socialize with a discharged patient outside of work Invite a current patient to their home Invite a discharged patient to their home
Workplace location	Develop a friendship with a current patient Develop a friendship with a discharged patient Socialize with a current patient outside of work Socialize with a discharged patient outside of work Invite a current patient to their home Invite a discharged patient to their home
Amount of time worked	Comment to patients on physical attractiveness

Table 98

Summary of the Significant ANOVA Results for Behaviours Around Dual Relationships and Sexual Misconduct

Independent Variable	Dependent Variable
Age	Developed a friendship with a current patient Socialized with a current patient outside of work Invited a discharged patient to their home
Gender	Developed a friendship with a current patient Socialized with a current patient outside of work Socialized with a discharged pt. Outside of work Dated a current patient or client Dated a discharged patient or client
Marital status	Invited a current patient to their home Dated a discharged patient or client Had a sexual relationship with a discharged pt.
Nursing education	Developed a friendship with a current patient Developed a friendship with a discharged patient Invited a current patient to their home
Years of experience	Socialize with a discharged patient outside of work
Specialty area	Provided care to family or friends Developed a friendship with a current patient Socialized with a current patient outside of work Socialized with a discharged pt. Outside of work Invited a current patient to their home
Current work area	Provided care to family or friends Developed a friendship with a current patient Developed a friendship with a discharged patient Socialized with a current patient outside of work Socialized with a discharged pt. Outside of work Invited a current patient to their home Invited a discharged patient to their home

(table continues)

Independent Variable	Dependent Variable
Workplace location	Developed a friendship with a current patient Developed a friendship with a discharged patient Socialized with a current patient outside of work Socialized with a discharged pt. Outside of work Invited a current patient to their home Invited a discharged patient to their home Dated a discharged patient or client Had a sexual relationship with a discharged pt
Amount of time worked	Commented on a patient's physical attractiveness

Nurse-Patient Relationships

When asked about their attitudes and behaviours around nurse-patient relationships, none of the participants reported that they had sex with a patient or client (99.3%). Six participants (0.7%) did not answer this question. The vast majority of the respondents also reported that they had never acted on sexual feelings toward a patient or client (98.3%), with seven participants (0.8%) reporting that they had rarely acted on sexual feelings toward a patient or client.

Most of the participants also reported that they had never received feedback that they were too involved with a patient or client (81.0%) or that they felt that other staff members were jealous of their relationship with a certain patient or client (73.6%). When asked if they had ever arrived early or stayed late to be with patients or clients, only 48.2% reported that they had never done so. As well, 40.2% of the respondents reported that they had never felt that they were the only one who understood a certain patient or client, and only 10.9% had never felt that certain staff members were too critical of their patient or client.

The nurses specializing in group therapy and those currently working in group therapy were the least likely to report that they had never felt that they were the only ones who understood a certain patient or client. The nurses specializing in child and adolescent mental health and those currently working in child and adolescent mental health were the least likely to report that they had never done so.

Nurses with an RN diploma and those specializing in forensic nursing were the most likely to report that they had never arrived early or stayed late to be with a patient or client for a longer period of time. Nurses with a master's in nursing and those specializing in child and adolescent mental health were the least likely to report that they had never done so. One nurse commented, "Community workers are different. We arrive early for appointments as we are concerned and feel assessment necessary. We stay late as we have to arrange treatment and then wait until plans are put in place and acted upon."

Nurses aged 31 to 40 were the most likely to report that they never received feedback that they were too involved with a patient or client, whereas the nurses aged 51 to 60 were the least likely to report that they had never received such feedback. One of the participants' comments about nurse-patient overinvolvement included:

> I have 2 close friends. (1) Met her husband while he was an inpatient in a psychiatric unit when she was his 'nurse.' Marriage was sustained for 3 years only and was volatile. (2) A male colleague who invites client and client's family for supper at his home. I have observed what I believe to be transference and counter-transference often in this situation. I care about my friends greatly and see the complications and difficulties due to the above involvement(s) as have the clients and professionals involved.

Table 99 provides a summary of the significant ANOVA results for the participants' attitudes and behaviours around nurse-patient relationships.

Table 99

Summary of the Significant ANOVA Results for Attitudes and Behaviours Around Nurse-Patient Relationships

Independent Variable	Dependent Variable
Age	Staff feedback too involved with a patient
Gender	Staff jealous of relationship with patient
Marital status	
Nursing education	Arrived early and/or stayed late with a patient
Years of experience	Staff feedback too involved with a patient
Specialty area	Only one to understand a patient Arrived early and/or stayed late with a patient
Current work area	Only one to understand a patient Arrived early and/or stayed late with a patient
Workplace location	
Amount of time worked	

CHAPTER FIVE

DISCUSSION

To avoid inappropriate or overinvolved behaviour in the workplace, the mental health nurse requires a clear understanding of the nature of professional boundaries, boundary crossings, and boundary violations. Appropriate professional boundaries are difficult to define. However, the needs of the patient or client must take priority over the needs of the nurse; and, unmistakably, the responsibility for maintaining professional boundaries lies with the mental health professional. Mental health nurses must be able to recognize and understand the range of behaviours that make up boundary crossings and boundary violations. A number of studies have investigated sexual boundary violations by physicians and psychologists; however, professional boundaries, boundary crossings, and boundary violations as they relate to boundary theory and the nurse-patient relationship have not been well studied in the nursing literature

As stated earlier, the purpose of this research was to explore the mental health nurse's attitudes and behaviours concerning professional boundaries, boundary crossings, and boundary violations within the nurse-patient relationship. The following research question was posed:

What are the attitudes and behaviours of mental health nurses practicing in Alberta toward professional boundaries, boundary crossings, and boundary violations?

The two secondary research questions that were investigated included:

1. What is the association between age, gender, marital status, type of nursing education, and years of experience in mental health nursing and the attitudes and behaviours of nurses toward professional boundaries, boundary crossings, and boundary violations?

2. What is the relationship between the area of specialty, current work area, geographical location of the work place, and the amount of time worked and the attitudes and behaviours of nurses toward professional boundaries, boundary crossings, and boundary violations?

The following assumptions were identified:

1. There are significant gender differences in the attitudes and in the practice of nurses regarding boundary crossings and violations.

2. The geographical location of the workplace, the area of nursing specialty, and the current work area affect the incidence of professional boundary crossings and violations.

3. The nurse's level of education and experience affects the incidence of professional boundary crossings and violations.

4. The nurses who commit serious boundary violations differ from their peers both in attitudes and behaviours.

Knowledge of Professional Boundaries

Attitudes Toward the Importance of Professional Boundaries

In recent years, interest in professional boundaries, boundary crossings, and boundary violations has increased significantly. The results of this survey indicated that the participants placed a very high value on the Importance of knowledge about professional boundaries. To date, limited research has been carried out regarding the attitudes of mental health nurses toward the importance of professional boundaries.

Professional Boundary Education

Nurses working in a city of over 500,000 were the most likely to report that they had obtained some type of professional boundary education, possibly because larger urban centres tend to have larger educational budgets. The participants working in group therapy were the most likely to report that they had received some type of professional boundary education. This stands to reason, because there is a great deal of published literature regarding psychotherapy and professional boundaries (Gabbard & Nadelson, 1995; Gutheil, 1994; Simon, 1992, 1993) and many of the principles of psychotherapy are utilized in a group therapy setting. Forensic patients can exhibit manipulative behaviour, and it was not surprising that forensic nurses were also more likely to report that they had received some type of professional boundary education. The participants working in the area of geriatric nursing were the least likely to report that they had obtained some type of professional boundary education. This lack of knowledge about professional boundaries could be reflected in the participants' comments that, in geriatric nursing, professional boundaries tend to become somewhat blurred.

The importance of professional boundaries in the workplace seems to have been recognized, with over half (50.8%) of the respondents reporting that they had received information through their workplaces. The respondents' professional associations could play a stronger role in providing information and education to their members and need to effectively disseminate the available information to ensure that the mental health nurses understand the importance of professional boundaries in the workplace. Although several respondents mentioned the value of the professional boundary educational session held during the Annual General Meeting of the Registered Psychiatric Nurses Association of Alberta (RPNAA) in 1999, only 25.3% of the RPNs reported receiving information regarding professional boundaries through the RPNAA. As well, only 28.4% of the RNs in this survey reported receiving information through their professional association despite the publication of a 1998 Alberta Association of Registered Nurses document on professional boundaries for registered nurses with guidelines for the nurse-client relationship.

Interest in Increasing Professional Boundary Knowledge

It was interesting to note that although the participants in this survey placed a high value on knowledge about professional boundaries, almost 100 nurses (10.5%) were not at all interested in learning more about professional boundaries. As well, 54 of the respondents (5.9%) did not answer this question. This could be a reflection of the ambivalence that some nurses have regarding the maintenance of a therapeutic relationship with a patient without being excessively formal and remote. The nature of the question or the fact that this was the last question of the survey could also have played a part in why 54 nurses did not answer the question.

Boundary Crossings

Gift Giving

Donen and Etkin (1997) have identified the acceptance of gifts from patients or clients as one of the initial steps in the slippery slope toward boundary violations. Nurses must balance the appropriateness of accepting gifts from patients and clients with the potential for setting the scene for future boundary violations. Morse (1991b) determined the structure and components of gift giving to nurses in a hospital setting. She acknowledged that gifts may be given to nurses by patients as (a) gifts to reciprocate for the care given, (b) "gifts intended to manipulate or to change the quality of care yet to be given, or to change the relationship between the nurse and the patient" (p. 602), (c) gifts given because of a perceived obligation, (d) "serendipitous gifts or perks and rewards received because of the nature of nursing or by chance" (p. 602), and (e) gifts given to the organization as a tribute to the superb nursing care received. According to Morse, nurses should accept gifts of gratitude and obligation, but manipulative gifts should be refused. Many of the nurses in the survey recognized the importance of accepting gifts given out of a perceived sense of obligation and the importance of accepting gifts of gratitude.

The participants specializing and currently working in forensic nursing and group therapy were among the respondents who were the most likely to report that they had never participated in gift-giving behaviours, and they appear to have recognized the importance of refusing gifts that could be used to manipulate the nurse-patient relationship. Forensic patients are often perceived to be the most manipulative of all patients. Nurses working in group therapy and forensic nursing were the most likely to report that they had received some type of professional boundary education.

Child and adolescent mental health is another area where the respondents indicated that professional boundaries were often unclear or blurred. It was interesting to note that nurses specializing in child and adolescent mental health nursing were the most likely to report that they strongly disagreed that it was appropriate to accept gifts of under $20.00 from patients or clients, but the nurses specializing in and currently working in child and adolescent mental health were also the least likely to report that they never accepted or given gifts of under $20.00 to patients or clients. There is no nursing literature examining the relationship between specialty area or current work area and gift giving.

Male nurses were more likely than female nurses to lend money to patients or clients. The reason for this is unclear, and there is no nursing literature examining the relationship between gender and gift giving. Little is known about mental health nurses' practices of giving gifts to patients or clients. According "special" treatment to patients and clients has also been identified as one of the steps in the slippery slope towards boundary violations (Donen & Etkin, 1997). Nurses must balance the appropriateness of both accepting and giving gifts to patients and clients with the potential for setting the scene for future boundary violations. More research is needed in all areas of gift giving.

Personal Disclosure

Nurses and other health professionals have been socialized to uphold a professional distance and have been educated not to disclose personal information about themselves to their patients. However, it is now believed that clinical self-disclosure can be therapeutic in the clinical environment if utilized appropriately (Deering, 1999; Van Servellen, 1997; Young, 1988). Deering has developed seven guidelines to consider when using therapeutic self-disclosure. These guidelines indicate that (a) the professional should use self-disclosure only to help the patient open up, not to meet the professional's own needs; (b) self-disclosure should be brief; (c) the professional should not imply that his or her own experience is exactly the same as the patient's; (d) self-disclose should be used only to describe situations that the professional has handled successfully; (e) the professional's comfort level with self-disclosure should be monitored; (f) cultural variations in the amount and type of self-disclosure deemed appropriate should be considered; and (g) the patient's need for privacy should be respected. There is no literature that focuses on the amount and type of information nurses are willing to disclose to patients (Ashmore & Banks, 2001).

Recently, the use of first names with patients or clients has become an accepted practice in mental health nursing. Younger nurses and those with fewer years of experience were the most likely to report that they strongly agreed that it was appropriate to use first names with patients or clients. These nurses were also more likely to report that they always used first names with patients or clients.

The age of the patient or client also appeared to be a factor that was considered by the participants when using first names with patients or clients. Those nurses working in child and adolescent mental health were the most likely to report that it was appropriate to use first names. Not unexpectedly, participants working in geriatric nursing were the least likely to use first names. The use of last names with geriatric patients or clients is often a sign of respect for their advanced years. It may also be an indication of the nurse's awareness of the geriatric patient or client's expectation of increased formality during interactions in a health care environment. As identified by Donen and Etkin (1997), the use of first names is the first step in the slippery slope towards boundary violations. Nurses must balance the appropriateness of using first names with patients and clients with the potential for setting the scene for future boundary violations.

Surprisingly, only 43.3% of the mental health nurses reported that they had never discussed their own religious beliefs with patients or clients. Many psychiatric patients or clients experience delusions of a religious nature (Stuart & Laraia, 1998). It is important that nurses address these religious issues without imposing their own religious beliefs onto the therapy situation. Excessive use of personal disclosure has, again, been identified as one of the steps in the slippery slope towards boundary violations (Donen & Etkin, 1997).

Most of the nurses reported that they had never cursed or sworn when interacting with patients or clients (64.2%). It is important that the nurse considers the cultural variations in the type of self-disclosure that is considered appropriate (Deering, 1999). Certain groups of patients and clients may be more offended by the use of cursing and swearing in a mental health setting than other groups. Not surprisingly, the participants working in the area of geriatric nursing were the most likely to report that they had never cursed or sworn, whereas the participants working in group therapy and forensic nursing were the least likely to report that they had never done so.

Engaging in personal conversations and excessive self-disclosure with a patient or client have also been identified as two of the behaviours in the slippery slope towards boundary violations (Donen & Etkin, 1997). Again the nurse must balance the appropriateness of personal disclosure with the potential for setting up future boundary violations. More research is needed in the use of personal disclosure by nurses in a mental health setting.

Confidentiality and Secrecy

When a nurse commits a boundary violation, one of the components that must be present is secrecy. Secrecy entails the nurse's selectively sharing information or keeping information from the patient or the treatment team (Linklater & MacDougall, 1993; Panelli, 1996; Peterson, 1992). The participants working in group therapy and forensic nursing were the most likely to report that they strongly disagreed that it is appropriate to keep a confidence regarding the patient or keep a confidence regarding others in the patient's life from the treatment team. This followed logically, because nurses working in group therapy and forensic nursing were the most likely to report that they had received some type of professional boundary education.

The importance of confidentiality has been identified as an important component of the therapeutic psychotherapy process (Simon, 1992). The sharing of information with the treatment team must be balanced with considerations for safeguarding the client's confidentiality. Secrecy about certain aspects of the nurse-patient relationship has also been identified as one of the steps in the slippery slope towards boundary violation (Donen & Etkin, 1997). Again, the nurse must consider the appropriateness of keeping confidences or secrets with the potential for developing future boundary violations.

Personal Space

Boundaries are thought to vary in both permeability and flexibility. *Permeability* is defined as "the degree of openness or closedness of a personal space boundary, ranging from maximally open to maximally closed" (Scott & Dumas, 1995, p. 15). The individual's degree of availability to the external environment is determined by the permeability of the boundary. The individual with flexible boundaries is able to choose a behavioural response that is situationally specific and culturally appropriate.

The participants specializing and currently working in forensic nursing and group therapy again were the most likely to report that they strongly disagreed that it is appropriate to engage in personal space behaviours, and they also indicated that they were the most likely to report that they had never actually done so. Again this followed logically, because nurses working in group therapy and forensic nursing were the most likely to report that they had received some type of professional boundary education. It is also considered by many to be situationally appropriate for nurses to avoid personal touch when interacting with patients or clients in a forensic or group therapy setting.

The participants specializing and currently working in geriatric nursing reported that they were the least likely to strongly disagree that it was appropriate to engage in personal space behaviours, and they also indicated that they were the least likely to state that they had never done so. It is important to note that the participants currently working in geriatric nursing were the least likely to report that they had received any type of professional boundary education. When interacting with geriatric patients or clients, it is essential for the nurse to identify the touch that is culturally appropriate for each patient. The nurse must also monitor for cues that the geriatric patient is uncomfortable with the amount of personal space exhibited by the nurse (Louis, 1981). Nurses must be able to identify their own personal space needs to ensure that they are not meeting their own personal space needs at the expense of the patient or client. Touching a patient or client has been identified as one of the behaviours that is exhibited in the slippery slope towards boundary violation (Donen & Etkin, 1997). Again, the nurse must balance the appropriateness of physical touch and appropriate personal space with the potential for encouraging future boundary violations.

Boundary Violations

Dual Relationships and Sexual Misconduct

The sexual involvement of a professional with a patient or client tends to follow a predictable course of progressive nonsexual treatment boundary violations with less serious forms of boundary violations preceding sexual impropriety (Coleman & Schaefer, 1986; Epstein, 1994; Folman, 1991; Gutheil & Gabbard, 1993; Kagle & Giebelhausen, 1994; Pope & Bouhoutsos, 1986; Simon, 1989, 1991, 1995; Wysoker, 2000). Sexual contact with patients following the completion of treatment is considered by many health professionals to be as unethical as sexual contact with current patients (Epstein & Simon, 1990; Gutheil, 1989). Sexual relationships have long-term harmful effects for the patient (Gutheil, 1989; Kluft, 1989) and damage the patient's self-esteem and ability to trust others (Gallop, 1993; Pope et al., 1986). The disadvantages to the patient appear to far outweigh any positive effects (Apfel & Simon, 1985; Collins, 1989). Although sexual attraction to a patient is a common and normal experience of health care practitioners (Briant, 1997; Folman, 1991; Gabbard, 1996; Kluft, 1989; Patterson & Blackshaw, 1993; Pope, 1987, 1988; Pope et al., 1986; Schafer, 1997), the needs of the client must take priority over the needs of the nurse and defining the boundaries in treatment is clearly the responsibility of the professional (Baron, 2001; Donen & Etkin, 1997; Epstein, 1994; Folman, 1991; Norman, 2000; Patterson & Blackshaw, 1993; Simon, 1991, 1992; Smith et al., 1997).

The results of this survey indicated that younger nurses (21-30 years of age) were the most likely to recognize the importance of strong boundaries when considering serious dual relationship and sexual misconduct boundary violations when interacting with current patients. They were, however, the least likely to report that they recognized the importance of maintaining boundaries with patient or clients in more minor dual relationship boundary violations. Younger nurses were also the least likely to recognize the importance of maintaining professional boundaries in serious dual relationship and sexual misconduct boundary violations with discharged patients or clients. When asked about their behaviours when interacting with patients or clients, the results indicated that younger nurses (21 to 30 years of age) were the most likely to report that they had never committed dual relationship and sexual misconduct boundary violations when interacting with current or discharged patients. Although none of the respondents reported that they had a sexual relationship with a current patient or client, the older participants reported that they had actually committed the most serious dual relationship and sexual misconduct boundary violations with current or discharged patients.

Diploma RPNs were the most likely to report that they had developed a friendship with a current patient or client, developed a friendship with a patient or client following discharge, invited a current patient or client to their home, dated a patient or client following discharge, or had a sexual relationship with a patient or client following discharge. These findings have implications for the formal RPN training program, and an increased emphasis on professional boundaries is indicated.

The need for social desirability, the tendency of the respondents to give a favourable picture of themselves, could have influenced the nurses' responses to the questions of serious dual relationship and sexual misconduct professional boundary violations. These findings also have implications for the professional associations and the workplace where increased education in the area of professional boundaries in dual relationship situations and serious boundary violations with both current and discharged patients should be instituted.

Nurse-Patient Relationships

None of the participants reported that they had engaged in sex with a patient. The vast majority also reported that they had never acted on sexual feelings with a patient or client, and only seven (0.8%) participants reported that they had rarely acted on sexual feelings with a patient or client. This is much lower than the prevalence rates found in other surveys of nurses (Bachmann et al., 2000, Nursing, 1974). Sexual attraction to a patient is a common and normal experience of health care practitioners (Bachmann et al.; Briant, 1997; Folman, 1991; Gabbard, 1996; Kluft, 1989; Patterson & Blackshaw, 1993; Pope, 1987, 1988; Pope et al., 1986; Schafer, 1997), but most health professionals feel guilty, anxious, or confused about the attraction (Briant; Pope et al.). Most mental health professionals have received little education in their training programs to help prevent them from acting on these feelings (Folman; Gabbard & Nadelson, 1995; Patterson & Blackshaw). These reactions and reasons may have affected the participants' responses to this question.

Summary

This survey indicated that both the male and female nurses reported attitudes and behaviours that were surprisingly similar. Nurses working in smaller communities were more likely to report engaging in boundary crossings and more minor boundary violations, whereas the respondents working in cities were the most likely to report more serious boundary violations and sexual misconduct.

Generally, nurses specializing in and currently working in forensic nursing and group therapy were the most likely to report that they had received some type of professional boundary education. They were also the most likely to report that they had never committed boundary crossings or boundary violations. The participants specializing in and currently working in geriatric nursing, on the other hand, were the least likely to report that they had received some type of boundary education and were the most likely to report that they had committed boundary crossings and more minor dual relationship boundary violations.

Nurses prepared at the diploma RPN level were the most likely to report serious dual relationship and sexual misconduct boundary violations. Increased emphasis and education in the area of professional boundaries should be instituted in formal education programs, in the workplace, and through the professional associations. The nurses' years of experience were not a significant factor in the frequency of boundary crossings and boundary violations.

Although the numbers are very low and must be interpreted with caution, mental health nurses working in Alberta have acted on sexual feelings toward clients and do have sexual relationships with discharged patients or clients. The nurses that commit these serious boundary violations do not differ significantly from their peers in attitudes or behaviours.

Limitations

Almost every survey completed in the past 30 years has different definitions of sexual contact, sexual relationships, and sexual misconduct. As well, very different types of survey instruments have been utilized. This lack of consistency makes it very difficult to compare findings about sexual misconduct among surveys.

The prevalence rates for sexual misconduct were much lower for nurses in this survey than the prevalence rates found for other professions. Neutral language was utilized in an attempt to overcome the participants' reluctance to answer questions about sexual relationships with patients or clients. Many of the participants could have been aware of the seriousness of sexual misconduct with patients and that sexual relationships with patients have been criminalized in many areas of the United States and in other countries. The anticipated constant error of social desirability could have resulted in an increase in socially acceptable responses by the participants. The other constant error that may have proved problematic for this survey was the anticipated acquiescent response set in which participants consistently agree or disagree with the nature of the question.

Thirteen experts in the area of mental health validated the questionnaire for content, clarity, appropriateness, and completion time. Despite these actions, the wording of the questions was reported to be problematic for a small number of participants. Some participants reported that they were offended that questions were asked about sexual relationships with patients.

Implications for Further Research

The sexual involvement of a nurse with a patient or client tends to follow a predictable course of progressive nonsexual treatment boundary violations with less serious forms of boundary violations preceding sexual impropriety. The therapeutic intensity and power imbalances inherent in nurse-patient interactions in a psychiatric or mental health setting set the stage for powerful transference and countertransference reactions. It is assumed that mental health nurses working in an outpatient setting or those working with patients for a longer length of time would have more opportunity to commit serious dual relationship and sexual misconduct violations and would therefore be more likely to actually violate professional boundaries. It is also assumed that more vulnerable patients or clients would be more likely to be the recipient of more serious dual relationship and sexual misconduct boundary violations. The literature indicated that male health professionals are much more likely to initiate and actually commit more serious boundary violations, which is congruent with accepted social behaviour regarding sexual contact. Women made up 83.4% of the respondents in this survey and typically reported that they had engage in fewer serious boundary violations than men do (Bachmann et al., 2000; Borys & Pope, 1989; Bouhoutsos et al., 1983; Gartrell et al, 1986, 1992; Holroyd & Brodsky, 1977; Pope et al., 1986). This gender issue may have impacted the results of the survey.

Future research questions could include:

1. What is the relationship between the position (job type) of the nurse and the nurses' type of workplace and the attitudes and behaviours of nurses toward professional boundaries, boundary crossings, and boundary violations?

2. What is the relationship between the condition of the patient treated and the length of patient stay, and the attitudes and behaviours of nurses toward professional boundaries, boundary crossings, and boundary violations?

3. What is the effect of the gender of the mental health nurse on professional boundary crossing and violation behaviours?

4. What are the motivations of the nurses who participate in sexual relationships with patients?

5. Is there a correlation between nurses who have a personal history of sexual abuse and boundary crossings and violations in patient care?

Conclusion

Increased education about the dynamics of transference, countertransference, and power in nurse-patient relationships (Blackshaw & Paterson, 1992; Collins, 1989; Folman, 1991; Gabbard, 1995, 1996; Gutheil & Gabbard, 1998; Marmor, 1970, 1972; Strasburger et al., 1992) and the context of therapist-patient contact is essential to the prevention of boundary violations (Gabbard, 1996; Gabbard & Menninger, 1991; Gabbard & Nadelson; Gutheil & Gabbard, 1993, 1998; Zelen, 1985). Mental health nurses need to understand their own personal boundaries and require additional education and training regarding boundary theory, personal and professional boundaries, boundary crossings, and boundary violations. Courses in professional ethics with a focus on the development of ethical decision making and judgement (Berliner, 1989; Blackshaw & Paterson; Pope & Bajt, 1988), gender-role behaviour, and gender-related issues (Blackshaw & Paterson) are also required. Further research studies in all areas of professional boundary crossings and boundary violations by mental health nurses are required to increase knowledge in the domain of nursing. All mental health nurses must participate in nurse-patient interactions in an ethical and respectful manner. Prevention of professional boundary violations through knowledge and education will promote clinical excellence in patient care.

REFERENCES

Akamatsu, T. J. (1988). Intimate relationships with former clients: National survey of attitudes and behaviour among practitioners. *Professional Psychology: Research and Practice, 19*, 454-458.

Alberta Association of Registered Nurses. (1998). *Professional boundaries for registered nurses: Guidelines for the nurse-client relationship*. Edmonton, AB: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

American Psychiatric Association. (1986). *The principles of medical ethics with annotations especially applicable to psychiatry*. Washington, DC: Author. (Original work published 1973)

Apfel, R. J., & Simon, B. (1985). Patient-therapist sexual contact, I: Psychodynamic perspectives on the causes and results. *Psychotherapy and Psychosomatics, 43*, 57-62.

Appelbaum, P. S. (1990). Statues regulating patient-therapist sex. *Hospital and Community Psychiatry, 41*(1), 15-16.

Appelbaum, P. S., & Jorgenson, J. D. (1991). Psychotherapist-patient sexual contact after termination of treatment: An analysis and a proposal. *American Journal of Psychiatry, 148*(11), 1466-1473.

Ashmore, R., & Banks, D. (2001). Patterns of self-disclosure among mental health nursing students. *Nurse Education Today, 21*, 48-57.

Averill, S. C., Beale, D., Benfer, B., Collins, D. T., Kennedy, L., Myers, J., Pope, D., Rosen, I., & Zoble, E. (1989). Preventing staff-patient sexual relationships. *Bulletin of the Menninger Clinic, 53*, 384-393.

Bachmann, K. M., Bossi, J., Moggi, F., Stirnemann-Lewis, F., Sommer, R., & Brenner, H. D. (2000). Nurse-patient sexual contact in psychiatric hospitals. *Archives of Sexual Behaviour, 29*(4), 335-347.

Backlar, P. (1996). The three Rs: Roles, relationships, and rules. *Community Mental Health Journal, 32*(5), 505-509.

Bader, E. (1994). Dual relationships: Legal and ethical trends. *Transactional Analysis Journal, 24*, 64-66.

Barakat, S., & De Cloedt, T. C. (1997). Boundary violations within the student-educator relationship. *Prairie Medical Journal, 67*(1), 19-20.

Baron, S. (2001). Boundaries in Professional relationships. *Journal of the American Psychiatric Nurses Association, 7*(1), 32-34.

Bennett, B. E., Bricklin, P. M., & VandeCreek, L. (1994). Response to Lazarus's "How certain boundaries and ethics diminish therapeutic effectiveness." *Ethics and Behaviour, 4*(3), 263-266.

Berliner, A. K. (1989). Misconduct in social work practice. *Social Work, 34*, 69-72.

Bernsen, A., Tabachnick, B. G., & Pope, K. S. (1994). National survey of social workers' sexual attraction to their clients: Results, implications, and comparison to psychologists. *Ethics and Behaviour, 4*(4), 369-388.

Blackshaw, S. L., & Patterson, P. G. (1992). The prevention of sexual exploitation of patients: Educational issues. *Canadian Journal of Psychiatry, 37*(5), 350-357.

Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology Research and Practice, 20*(5), 283-293.

Bouhoutsos, J., Holroyd, J., Lerman, H., Forer, B. R., & Greenberg, M. (1983). Sexual intimacy between psychotherapists and patients. *Professional Psychology: Research and Practice, 14*(2), 185-196.

Briant, S. (1997). Too close for comfort. *Nursing Times, 93*(6), 22-24.

Briant, S., & Freshwater, D. (1998). Exploring mutuality within the nurse-patient relationship. *British Journal of Nursing, 7*(4), 204-211.

Brown, L. S. (1988). Harmful effects of posttermination sexual and romantic relationships between therapists and their former clients. *Psychotherapy, 25*(2), 249-255.

Brown, L. S. (1994). Concrete boundaries and the problem of literal-mindedness: A response to Lazarus. *Ethics and Behaviour, 4*(3), 275-281.

Brownlee, K. (1996). Ethics in community mental health care: The ethics of non-sexual dual relationships: A dilemma for the rural mental health professional. *Community Mental Health Journal, 32*(5), 497-503.

Butler, S., & Zelen, S. L. (1977). Sexual intimacies between therapists and patients. *Psychotherapy: Theory, Research, and Practice, 14*(2), 139-145.

Cameron, M. E. (1997). Legal and ethical issues: Professional boundaries in nursing. *Journal of Professional Nursing, 13*(3), 142.

Canadian Federation of Mental Health Nurses. (1995). *The standards of psychiatric and mental health nursing practice*. Ottawa, ON: Author.

Carey, E. T., Noll, J., Rasmussen, L., Searcy, B., & Stark, N. L. (1989). Psychodynamic nursing. In A. Marriner-Tomey (Ed.), *Nursing theorists and their work* (2nd ed., pp. 203-218). Toronto, ON: C. V. Mosby.

Carr, M. L., Robinson, G. E., Stewart, D. E., & Kussin, D. (1991). A survey of Canadian psychiatric residents regarding resident-educator sexual contact. *American Journal of Psychiatry, 148*(2), 216-220.

Coleman, E., & Schaefer, S. (1986). Boundaries of sex and intimacy between client and counselor. *Journal of Counselling and Development, 64*, 341-344.

College of Physicians and Surgeons of Alberta. (1992). *Doctor-patient sexual involvement: Policy paper and future initiatives*. Edmonton, AB: Author.

College of Physicians and Surgeons of Ontario. (1991). *The final report of the task force on sexual abuse of patients*. Toronto, ON: Author.

Collins, D. T. (1989). Sexual involvement between psychiatric hospital staff and their patients. In G. Gabbard (Ed.), *Sexual exploitation in professional relationships* (pp. 151-163). Washington, DC: American Psychiatric Press.

Committee on Physician Sexual Misconduct. (1992). *Crossing the boundaries: The report of the committee on physician sexual misconduct*. Vancouver, BC: College of Physicians and Surgeons of British Columbia.

Curtis, J. M. (1981). Indications and contraindications in the use of therapist's self-disclosure. *Psychological Reports, 49*, 499-507.

Curtis, L. C., & Hodge, M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. *Psychosocial Rehabilitation Journal, 18*(2), 13-33.

Dahlberg, C. C. (1970). Sexual contact between patient and therapist. *Contemporary Psychoanalysis, 6*, 107-124.

Deering, C. G. (1999). To speak or not to speak: Self-disclosure with patients. *American Journal of Nursing, 99*(1), 34-39.

Donen, N., & Etkin, M. (1997). Boundaries: Smaller than you think. *Prairie Medical Journal, 67*(1), 13-15.

Edelstein, L. (1943). *The Hippocratic oath: Text, translation, and interpretation*. Baltimore: John Hopkins University Press.

Epstein, R. S. (1994). *Keeping boundaries: Maintaining safety and integrity in the psychotherapeutic process*. Washington, DC: American Psychiatric Press.

Epstein, R. S., & Simon, R. I. (1990). The exploitation index: An early warning indicator of boundary violations in psychotherapy. *Bulletin of the Menninger Clinic, 54*(4), 450-465.

Epstein, R. S., Simon, R. J., & Kay, G. G. (1992). Assessing boundary violations in psychotherapy. *Bulletin of the Menninger Clinic, 56*(2), 150-166.

Feldman-Summers, S., & Jones, G. (1984). Psychological impacts of sexual contact between therapists or other health care practitioners and their clients. *Journal of Consulting and Clinical Psychology, 52*(6), 1054-1061.

Folman, R. Z. (1991). Therapist-patient sex: Attractions and boundary problems. *Psychotherapy, 28*(1), 168-173.

Freud, S. (1958). Observations on transference love: Further recommendations on the technique of psycho-analysis III. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 157-173). London: Hogarth Press. (Original work published 1915)

Frick, D. E. (1994). Nonsexual boundary violations in psychiatric treatment. In J. M. Oldham and M. B. Riba (Eds.), *American psychiatric press review of psychiatry: Vol. 13* (pp. 415-432). American Psychiatric Press.

Frick, D. E., McCartney, C. F., & Lazarus, J. A. (1995). Supervision of sexually exploitative psychiatrists: APA district branch experience. *Psychiatric Annals, 25*(2), 113-117.

Gabbard, G. O. (1991). Psychodynamics of sexual boundary violations. *Psychiatric Annals, 21*(11), 651-655.

Gabbard, G. O. (1994). Teetering on precipice: A commentary on Lazarus's "How certain boundaries and ethics diminish therapeutic effectiveness." *Ethics and Behaviour, 4*(3), 283-286.

Gabbard, G. O. (1995). The early history of boundary violation in psychoanalysis. *Journal of the American Psychoanalytic Association, 43*(4), 1115-1136.

Gabbard, G. O. (1996). Lessons to be learned from the study of sexual boundary violations. *American Journal of Psychotherapy, 50*(3), 311-322.

Gabbard, G. O., & Menninger, W. W. (1991). An overview of sexual boundary violations in psychiatry. *Psychiatric Annals, 21*(11), 649-650.

Gabbard, G. O., & Nadelson, C. (1995). Professional boundaries in the physician-patient relationship. *Journal of the American Medical Association, 273*(18), 1445-1449.

Gallop, R. (1993). Sexual contact between nurses and patients. *Canadian Nurse, 2*, 28-31.

Gallop, R. (1998). Abuse of power in the nurse-client relationship. *Nursing Standard,* 12(37), 43-47.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (1986). Psychiatrist-patient sexual contact: Results of a national survey, I: Prevalence. *American Journal of Psychiatry, 143*(9), 1126-1131.

Gartrell, N., Herman, J., Olarte, S., Localio, R., & Feldstein, M. (1988). Psychiatric residents' sexual contact with educators and patients: Results of a national survey. *American Journal of Psychiatry, 145*(6), 690-694.

Gartrell, N. K., Milliken, N., Goodson, W. H., Thiemann, S., & Lo, B. (1992). Physician-patient sexual contact: Prevalence and problems. *The Western Journal of Medicine, 157*, 139-143.

Gechtman, L. (1989). Sexual contact between social workers and their clients. In G. Gabbard (Ed.), *Sexual exploitation in professional relationships* (pp. 27-33). Washington, DC: American Psychiatric Press.

Gechtman, L., & Bouhoutsos, J. C. (1985, October). *Social worker's attitudes and practices regarding erotic and nonerotic physical contact with their clients.* Paper presented at the National Federation of Societies for Clinical Social Work Conference. Universal City, CA.

Gillies, D. A. (1989). *Nursing management: A systems approach*. Philadelphia, PA: W. B. Saunders.

Glaser, R. D., & Thorpe, J. S. (1986). Unethical intimacy: A survey of sexual contact and advances between psychology educators and female graduate students. *American Psychologist, 41*(1), 43-51.

Goisman, R. M., & Gutheil, T. G. (1992). Risk management in the practice of behaviour therapy: Boundaries and behaviour. *American Journal of Psychotherapy, 46*(4), 532-543.

Gordon, G. H., Labby, D., & Levinson, W. (1992). Sex and the teacher-learner relationship in medicine. *Journal of General Internal Medicine, 7*(4), 443-447.

Gordy, H. E. (1978). Gift giving in the nurse-patient relationship. *American Journal of Nursing, 78*(6), 1026-1028.

Gutheil, T. G. (1989). Borderline personality disorder, boundary violations, and patient-therapist sex: Medicolegal pitfalls. *American Journal of Psychiatry, 146*(5), 597-602.

Gutheil, T. G. (1994). Risk management at the margins: Less-familiar topics in psychiatric malpractice. *Harvard Review of Psychiatry, 2*(4), 214-221.

Gutheil, T. G., & Gabbard, G. O. (1992). Obstacles to the dynamic understanding of therapist-patient sexual relations. *American Journal of Psychotherapy, 46*(4), 515-525.

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry, 150*(2), 188-196.

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry, 155*(3), 409-414.

Gutheil, T. G., & Simon, R. I. (1995). Between the chair and the door: Boundary issues in the therapeutic "Transition Zone." *Harvard Review of Psychiatry, 2*(6), 336-340.

Herman, J. L., Gartrell, N., Olarte, S., Feldstein, M., & Localio, R. (1987). Psychiatrist-patient sexual contact: Results of a national survey, II: Psychiatrists' attitudes. *American Journal of Psychiatry, 144*(2), 164-169.

Holroyd, J. C., & Brodsky, A. M. (1977). Psychologists' attitudes and practices regarding erotic and nonerotic physical contact with patients. *American Psychologist, 32*(10), 843-849.

Hoover, D. (1995). Impaired personal boundaries: A proposed nursing diagnosis. *Perspectives in Psychiatric Care, 31*(3), 9-13.

Jayaratne, S., Croxton, T., & Mattison, D. (1997). Social work professional standards: An exploratory study. *Social Work, 42*(2), 187-199.

Kagle, J. D., & Giebelhausen, P. N. (1994). Dual relationships and professional boundaries. *Social Work, 39*(2), 213-220.

Kardener, S. H. (1974). Sex and the physician-patient relationship. *American Journal of Psychiatry, 133*(10), 1134-1136.

Kardener, S. H., Fuller, M., & Mensh, I. (1973). A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients. *American Journal of Psychiatry, 130*(10), 1077-1081.

Kluft, R. P. (1989). Treating the patient who has been sexually exploited by a previous therapist. *Psychiatric Clinics of North America, 12*(2), 483-500.

Komaromy, M., Bindman, A. B., Halver, R. J., & Sande, M. A. (1993). Sexual harassment in medical training. *New England Journal of Medicine, 328*(5), 322-326.

Lazarus, A. A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics and Behaviour, 4*(3), 255-261.

Lerner, R. (1988). *Boundaries for co-dependents*. Center City, MN: Hazalden Foundation.

Levine, M. H. (1972). *Psychiatry and ethics*. New York: George Braziller.

Linklater, D., & MacDougall, S. (1993). Boundary issues: What do they mean for family physicians? *Canadian Family Physician, 39*, 2569-2573.

Louis, M. (1981). Personal space boundary needs of elderly persons: An empirical study. *Journal of Gerontological Nursing*, 7(7), 395-400.

Margittai, K. J., & Moscarello, R. (1994). Medical students' experience of abuse: A Canadian perspective. *Annuals of the Royal College of Physicians and Surgeons of Canada, 27*, 199-204.

Marmor, J. (1970). The seductive psychotherapist. *Psychiatry Digest, 30*, 10-16.

Marmor, J. (1972). Sexual acting-out in psychotherapy. *American Journal of Psychoanalysis, 32*(1), 3-8.

McCartney, J. L. (1966). Overt transference. *Journal of Sex Research, 2*(3), 227-237.

Morse, J. M. (1989). Reciprocity for care: Gift giving in the patient-nurse relationship. *The Canadian Journal of Nursing Research, 21*(1), 33-46.

Morse, J. M. (1991a). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing, 16*, 455-468.

Morse, J. M. (1991b). The structure and function of gift giving in the patient-nurse relationship. *Western Journal of Nursing Research, 13*(5), 597-615.

Munsat, E. M., & Riordan, J. J. (1990). Under wraps: Prevalence of staff-patient sexual interactions on inpatient units. *Journal of Psychosocial Nursing, 28*(9), 23-26.

National Association of Social Workers. (1993). *NASW code of ethics*. Washington, DC: Author.

National Council of State Boards of Nursing. (1995). *Disciplinary guidelines for managing sexual misconduct cases*. Chicago: The National Council of State Boards of Nursing.

National Council of State Boards of Nursing. (1996). Raising awareness of professional boundaries and sexual misconduct: Nursing faculty are encouraged to take a proactive role. *Issues, 17*(2), 11-13.

Norman, A. (2000). Keep your distance. *Nursing Times, 96*(21), 30-31.

Nursing (1974). Nursing ethics: What are your personal and professional standards? *Nursing, 4*(9), 34-44.

Panelli, R. (1996). Professional boundaries in nursing. *Colorado Nurse, 96*(3), 12.

Patterson, P. G. R., & Blackshaw, S. (1993). Abuse of patients by physicians. *Medicine North America, 10*, 721-724.

Pennington, S., Gafner, G., Schilit, R., & Bechtel, B. (1993). Addressing ethical boundaries among nurses. *Nursing Management, 24*(6), 36-39.

Peplau, H. E. (1952). *Interpersonal relations in nursing*. New York: Putnam. (Reprinted by Springer Publishing, New York, 1991)

Perry, J. A. (1976). Physicians' erotic and nonerotic physical involvement with patients. *American Journal of Psychiatry, 133*(7), 838-840.

Peterson, M. (1992). *At personal risk: Boundary violations in professional-client relationships*. New York: Norton.

Pilette, P. C., Berck, C. B., & Achber, L. C. (1995). Therapeutic management of helping boundaries. *Journal of Psychosocial Nursing, 33*(1), 40-47.

Pope, K. S. (1987). Preventing therapist-patient sexual intimacy: Therapy for a therapist at risk. *Professional Psychology: Research and Practice, 18*(6), 624-628.

Pope, K. S. (1988). How clients are harmed by sexual contact with mental health professionals: The syndrome and its prevalence. *Journal of Counseling and Development, 67*(4), 222-226.

Pope, K. S. (1989). Teacher-student sexual intimacy. In G. O. Gabbard (Ed.), *Sexual exploitation in professional relationships* (pp. 163-176). Washington, DC: American Psychiatric Press.

Pope, K. S. (1991). Dual relationships in psychotherapy. *Ethics and Behaviour, 1*(1), 21-34.

Pope, K. S. (1993). Licensing disciplinary actions for psychologists who have been sexually involved with a client: Some information about offenders. *Professional Psychology, 24*(3), 374-377.

Pope, K. S., & Bajt, T. R. (1988). When laws and values conflict: A dilemma for psychologists. *American Psychologist, 43*(10), 828-829.

Pope, K. S., & Bouhoutsos, J. C. (1986). *Sexual intimacy between therapists and patients*. New York: Praeger.

Pope, K. S., Keith-Spiegel, P., & Tabachnick, B. G. (1986). Sexual attraction to clients: The human therapists and the (sometimes) inhuman training system. *American Psychologist, 41*(2), 147-158.

Pope, K. S., Levenson, H., & Schover, L. R. (1979). Sexual intimacy in psychology training: Results and implications of a national survey. *American Psychologist, 34*(8), 682-689.

Pope, K. S., Schover, L. R., & Levenson, H. (1980). Sexual behaviour between clinical supervisors and trainees: Implications for professional standards. *Professional Psychology, 11*, 157-162.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviours of psychologists as therapists. *American Psychologist, 42*(11), 993-1006.

Pope, K. S., & Vetter, V. A. (1991). Prior therapist-patient sexual involvement among patients seen by psychologists. *Psychotherapy, 28*, 429-438.

Ramsdell, P. S., & Ramsdell, E. R. (1994). Counselor and client perceptions of the effect of social and physical contact on the therapeutic process. *Clinical Social Work Journal, 22*, 91-104.

Reed, P. G. (1996). Peplau's interpersonal relations model. In J. J. Fitzpatrick & A. L. Whall (Eds.), *Conceptual models of nursing: Analysis and application* (3rd ed., pp. 55-76). Stamford, CT: Appleton & Lange.

Reich, W. (1949). *Character analysis*. New York: Noonday Press.

Robinson, W. L., & Reid, P. T. (1985). Sexual intimacies in psychology revisited. *Professional Psychology: Research and Practice, 16*(4), 512-520.

Robinson, G. E., & Stewart, D. E. (1996a). A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment: Part 1: Content. *Canadian Medical Association Journal, 154*(5), 643-649.

Robinson, G. E., & Stewart, D. E. (1996b). A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment: Part 2: Teaching method. *Canadian Medical Association Journal, 154*(7), 1021-1025.

Schafer, P. (1997). When a client develops an attraction: Successful resolution versus boundary violation. *Journal of Psychiatric and Mental Health Nursing, 4*, 203-211.

Schoener, G. R. (1995). Employer/supervisor liability and risk management: An administrator's view. In J. Gonsiorek (Ed.), *The breach of trust: Sexual exploitation by health care professionals and clergy* (pp. 300-316). Newbury, CA: Sage.

Schoener, G. R. (1996). *Assessment, treatment, & supervision of professionals found guilty of sexual misconduct and related boundary violations*. Paper presented at the Psychologist Association of Alberta on dealing with sexual misconduct and other boundary violations, Edmonton, AB.

Schoener, G. R., & Luepker, E. T. (1996). Boundaries in group therapy: Ethical and practice issues. In B. DeChant (Ed.), *Women and group psychotherapy: Theory and practice* (pp. 373-399). New York: Guildford Press.

Schroder, P. J. (1985). Recognizing transference and countertransference. *Journal of Psychosocial Nursing, 23*(2), 21-26.

Scott, A. L. (1988). Human interaction and personal boundaries. *Journal of Psychosocial Nursing, 26*(8), 23-27.

Scott, A. L. (1993). A beginning theory of personal space boundaries. *Perspectives in Psychiatric Care, 29*(2), 12-21.

Scott, A. L., & Dumas, R. E. (1995). Personal space boundaries: Clinical applications in psychiatric mental health nursing. *Perspectives in Psychiatric Care, 31*(3), 14-19.

Shepard, M. (1971). *The love treatment: Sexual intimacy between patients and psychotherapists*. New York: Peter H. Wyden.

Simon, R. I. (1988). *Concise guide to clinical psychiatry and the law* (1st ed.). Washington DC: American Psychiatric.

Simon, R. I. (1989). Sexual exploitation of patients: How it begins before it happens. *Psychiatric Annals, 19*, 104-112.

Simon, R. I. (1991). Psychological injury caused by boundary violation precursors to therapist-patient sex. *Psychiatric Annals, 21*(10), 614-619.

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *Bulletin of American Academic Psychiatry Law, 20*, 269-288.

Simon, R. I. (1995). The natural history of therapist sexual misconduct: Identification and prevention. *Psychiatric Annals, 25*(2), 90-94.

Sloane, J. A. (1993). Offences and defences against patients: A psychoanalyst's view of the borderline between empathic failure and malpractice. *Canadian Journal of Psychiatry, 38*, 265-273.

Smith, L. L., Taylor, B. B., Keys, A. T., & Gornto, S. B. (1997). Nurse-patient boundaries: Crossing the line. *American Journal of Nursing, 97*(12), 26-32.

Sommers-Flanagan, R., Elliott, D., & Sommers-Flanagan, J. (1998). Exploring the edges: Boundaries and breaks. *Ethics and Behaviour, 8*(1), 37-48.

Stake, J. E., & Oliver, J. (1991). Sexual contact and touching between therapist and clients: A survey of psychologists' attitudes and behaviour. Professional Psychology: *Research and Practice, 22*, 297-307.

Stone, M. H. (1975). Management of unethical behaviour in a psychiatric hospital staff. *American Journal of Psychotherapy, 29*(3), 391-401.

Stoner, J. F. (1982). *Management*. Englewood Cliffs, NJ: Prentice Hall.

Strasburger, I. H., Jorgenson, L., & Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. *American Journal of Psychotherapy, 46*(4), 544-555.

Stuart, G. W., & Laraia, M. T. (1998). *Principles and Practice of Psychiatric Nursing*. St. Louis: C. V. Mosby.

Taylor, B. J., & Wagner, N. N. (1976). Sex between therapists and clients: A review and analysis. *Professional Psychology: Research and Practice, 7*, 593-601.

Valentich, M., & Gripton, J. (1992). Dual relationships: Dilemmas and doubts. *Canadian Journal of Human Sexuality, 1*(3), 155-166.

Van Servellen, G. M. (1997). *Communication skills for the health care professional: Concepts and techniques*. Gaithersburg, MD: Aspen.

Vinson, J. S. (1987). Use of complaint procedures in cases of therapist-patient sexual contact. *Professional Psychology: Research and Practice, 18*(2), 159-164.

Whitfield, C. L. (1993). *Boundaries and relationships: Knowing, protecting, and enjoying the self*. Deerfield Beach, FL: Health Communications.

Wysoker, A. (2000). Legal and ethical considerations: Sexual misconduct. *Journal of the American Psychiatric Association, 6*(4), 131-132.

Young, J. C. (1988). Rationale for clinician self-disclosure and research agenda. IMAGE: *Journal of Nursing Scholarship, 20*(4), 196-199.

Zelen, S. L. (1985). Sexualization of therapeutic relationships: The dual vulnerability of patient and therapist. *Psychotherapy, 22*(2), 178-185.

APPENDIX A

FREQUENCY STUDIES OF SEXUAL INTIMACY

Appendix A

Frequency Studies of Sexual Intimacy

Table A1

Self-Report Studies of Sexual Intimacy with Patient/Clients

Publish Date	Study	Profession	Location	Return Rate	Percent Male	Percent Female
1973	Kardener, Fuller, & Mensh	Physicians	LA County	46%	10.0	N/A
1976	Perry	Psychiatrists	CA & NY	33%	N/A	0.0
1977	Holroyd & Brodsky	Psychologists	National, US	70%	5.5	0.6
1983	Bouhoutsos et al.	Psychologists	California	16%	4.8	0.8
1986	Pope, Keith-Spiegel, & Tabachnick	Psychologists	National, US	59%	9.4	2.5
1986	Gartrell et al.	Psychiatrists	National, US	26%	7.1	3.1
1987	Pope, Tabachnick, & Keith-Spiegel	Psychologists	National, US	46%	3.6	0.5
1988	Akamatsu	Psychologists	National, US	40%	3.5	2.3
1989	Gechtman	Social Workers	National, US	54%	G3.8	0.0
1989	Borys & Pope	*	National, US	49%	0.9	0.2
1991	Pope & Vetter	Psychologists	National, US	50%	N/A	N/A
1991	Stake & Oliver	Psychologists	Missouri, US	31%	N/A	N/A
1992	Gartrell et al.	Psychiatrists	National, US	19%	10.0	4.0
1994	Bernsen, Tabachnick, & Pope	Social Workers	National, US	45%	3.6	0.5
1997	Jayaratne, Croxton, & Mattison	Social Workers	Michigan, US	57%	N/A	N/A
2000	Bachmann et al.	Nurses	Switzerland	39%	17.0	11.0

Note: Adapted from Pope, 1988, 1993; Pope & Bouhoutsos, 1986.
*Psychologists, psychiatrists and social workers

Table A2

Self-Report Studies of Teacher-Student Boundary Violations and Sexual Intimacy

Publish Date	Study	Profession	Location	Return Rate
1979	Pope, Levenson, & Schover	Psychologists	National, US	48%
1985	Robinson & Reid	Psychologists	National, US	30%
1986	Glaser & Thorpe	Psychologists	Canada & US	44%
1988	Gartrell et al.	Psych Resid	National, US	50%
1991	Carr et al.	Psych Resid	National, Canada	59%
1993	Komaromy, Bindman & Halver	Int Med Resid	U of California	43%
1994	Margittai & Moscarello	Med students	U of Toronto	88%

APPENDIX B

PARTICIPANT DEMOGRAPHIC PROFILE

Appendix B

Table B1

Participant Demographic Profile

Value		N	% of Respondents
Education			
RPNs			
RPN diploma only		430	46.6
Advanced diploma		8	0.9
BScMH		3	0.3
RNs			
RN diploma only		253	27.4
RN diploma & Mental Health Cert.		3	0.3
Both RN and RPN diploma		37	4.0
BScN/BN		156	16.9
BScN with RPN diploma		3	0.3
MScN/MN		23	2.5
PhD		1	0.1
Age			
Mean	45 years	904	
Median	45 years	904	
Mode	47 years	904	
Age Ranges			
21-30		52	5.6
31-40		250	27.1
41-50		338	36.6
51-60		236	25.6
61-70		28	3.0
Gender			
Female		770	83.4
Male		146	15.8
Marital Status			
Married		628	68.0
Common law		71	7.7
Separated/Divorced		125	13.5
Widowed		12	1.3
Single		82	8.9

Note. Frequencies may not add up to 923 (total n) due to nonresponses for specific variables.

APPENDIX C

PARTICIPANT WORK HISTORY

Appendix C

Table C1

Participant Work History

Value	N	% of Respondents
Years Worked In Mental Health		
Mean 16.2 years	899	
Median 15.0 years	899	
Mode 10 years	899	
Years Experience		
0-10	286	31.0
11-20	347	37.6
21-30	212	23.0
31-40	50	5.4
41-50	4	0.4
Place Of Employment*		
Acute Care Hospital	446	48.3
Provincial Institution	184	19.9
Nursing Home/Continuing Care Facility	54	5.9
Clinic/Physician's Office	12	1.3
Private Agency	21	2.3
Home Care	10	1.1
Community/Outpatient Program	212	23.0
University/College	16	1.7
School	4	0.4
Private Practice	28	3.0
Other	69	7.5
Workplace Location		
City (>500,000)	561	60.8
City (<500,000)	146	15.8
Town	146	15.8
Village/Hamlet	4	0.4
Rural Area	26	2.8

Note. Frequencies may not add up to 923 (total n) due to nonresponses for specific variables.

*Place of employment may add up to more than 923 as nurses often work in more than one setting.

APPENDIX D

CLINICAL AREAS

Appendix D

Table D1

Clinical Areas

Value		N	% of Respondents
Years Worked in Current Area			
Mean	10.6 years	888	
Median	10.0 years	888	
Mode	10 years	888	
Current Work Area			
Geriatrics		142	15.4
Adult		443	48.0
Child and Adolescent		76	8.2
Forensic		49	5.3
Group Therapy		34	3.7
None		21	2.3
Other		139	15.1
Area Of Specialty			
Geriatrics		136	14.7
Adult		455	49.3
Child and Adolescent		74	8.0
Forensic		42	4.6
Group Therapy		40	4.3
None		52	5.6
Other		87	9.4
Areas Worked In Past*			
Geriatrics		523	56.7
Adult		674	73.0
Child and Adolescent		318	34.5
Forensic		225	24.4
Group Therapy		330	35.8
No Past Work		51	5.5
Other		142	15.4

Note. Frequencies may not add up to 923 (total n) due to nonresponses for specific variables.

*Areas worked in past may add up to more than 923 as nurses often work in more than one setting.

APPENDIX E

POSITION TITLE, POSITION TYPE, AND AMOUNT OF TIME WORKED

Appendix E

Table E1

Position Title, Position Type, and Amount of Time Worked

Value	N	% of Respondents
Position Title*		
Staff Nurse	690	74.8
Charge Nurse/Team Leader	91	9.9
Head nurse/Assistant Head Nurse	7	0.8
Manager/Assistant Manager	44	4.8
Director/Assistant Director	13	1.4
Administrator	4	0.4
Educator/Clinical Specialist	45	4.9
Professor	3	0.3
Consultant	50	5.4
Other	146	15.8
Position Type*		
Permanent	730	79.1
Temporary	49	5.3
Casual	140	15.2
Contract	27	2.9
Self-employed	18	2.0
Other	31	3.4
Amount of Time Worked		
Part-time	357	38.7
Full-time	473	51.2
More than full-time	63	6.8

Note. Frequencies may not add up to 923 (total n) due to nonresponses for specific variables.

*Position Title and Position Type may add up to more than 923 as nurses often work in more than one setting.

APPENDIX F

SURVEY INSTRUMENT

Appendix F

Survey Instrument

UNIVERSITY OF ALBERTA

March 20, 2000

Dear Mental Health Nurse,

You are invited to fill out the enclosed questionnaire about professional boundaries and the attitudes and practices of nurses working in the mental health field. Registered nurses (RNs) currently actively registered with the Alberta Association of Registered Nurses (AARN) and registered psychiatric nurses (RPNs) currently actively registered with the Registered Psychiatric Nurses Association of Alberta (RPNAA) are being surveyed. The title of this survey is "Attitudes of Alberta Mental Health Nurses Toward Professional Boundaries, Boundary Crossings, and Boundary Violations in Patient Care". This questionnaire should take about 15 minutes to complete.

As a mental health nurse in Alberta, your attitudes and behaviours are important. All attitudes and behaviours are of equal value and will help to provide a full and realistic picture regarding professional boundaries, boundary crossings and boundary violations. You will also be asked about your work experience, place of employment, and education. This questionnaire will be sent to both RPNs and RNs. If you receive a second questionnaire please complete only one.

Your participation in this study is voluntary. By filling out and mailing this questionnaire, it is assumed that you have consented to participate in this study. Leave any questions that you do not wish to answe blank. Please do not write your name anywhere on the survey.

This questionnaire will be mailed out by companies associated with the AARN and the RPNAA. The investigator will never have access to your name or address and you will remain anonymous. All answers will be put into a form that cannot be traced back to you as an individual. The study data will be kept in a secure area accessible by only the research team for at least seven years after the study is completed. The data obtained in this study may be used for another research study in the future. If any further analysis is conducted with the study, additional ethics approval will be sought first. The results of this study may be published.

This study of the attitudes and behaviors of Alberta nurses regarding professional boundaries is being carried out by Joan Campbell, RN, BScN for her Master of Nursing thesis through the University of Alberta. If you have any questions or concerns about the survey please contact Joan Campbell at (780) 450-7586 or via E-mail at rjcampbe@caritas.ab.ca. The thesis supervisor for this project is Dr. Olive Yonge, Professor, Faculty of Nursing. She may be reached at (780) 492-2402. You may also contact Dr Janice Lander, Professor and Associate Dean, Research in the Faculty of Nursing at the University of Alberta at (780) 492-6763. This study has the support of the Faculty of Nursing at the University of Alberta and the Grey Nuns Community Hospital and Health Centre.

Place the completed questionnaire in the envelope provided and mail it. If you would like to see the results of this survey, please complete the reply card and mail it separately.

Sincerely

Joan Campbell

R. Joan Campbell, RN, BScN

Undergraduate Office
3-109 Clinical Sciences Building
Phone: (780) 492-9546
Fax: (780) 492-4844

Graduate Office
3-134 Clinical Sciences Building
Phone: (780) 492-6251
Fax: (780) 492-2551

Research Office
3-126 Clinical Sciences Building
Phone: (780) 492-6832
Fax: (780) 492-2551

Teaching Office
4-111 Clinical Sciences Building
Phone: (780) 492-6248
Fax: (780) 492-2551

General Information
3-114 Clinical Sciences Building
Phone: (780) 492-4404
Fax: (780) 492-2551

Office of the Dean
3-120 Clinical Sciences Building
Phone: (780) 492-6236
Fax: (780) 492-6029

Faculty of Nursing

3rd Floor, Clinical Sciences Building • University of Alberta • Edmonton • Canada • T6G 2G3
www.ua-nursing.ualberta.ca

UNIVERSITY OF ALBERTA

Survey of Alberta Mental Health Nurses and Professional Boundaries

Instructions

All of your answers in this questionnaire will be kept strictly confidential.

- This questionnaire should take about 15 minutes to complete.
- By filling out and mailing this questionnaire, it is assumed that you have consented to participate in this study.
- Leave any questions that you do not wish to answer blank.
- Please do not write your name anywhere on the survey.
- If you have any questions or concerns regarding the survey, please contact Joan Campbell at (780) 450-7588 or via E-mail at rjcampbe@caritas.ab.ca
- Place the completed questionnaire in the envelope provided and mail it.
- If you would like to see the results of this survey, please complete the enclosed card and mail it seperately.

Survey of Alberta Mental Health Nurses
and
Professional Boundaries

Please read each question carefully and try to answer all of them. These questions can be answered by writing in the blank space provided or by circling the number next to the answer that you choose.

All information that you provide in this questionnaire is strictly confidential.

1. When were you born? ______ (year)

2. What is your gender?

Female	1
Male	2

3. What is your current marital status? **Answer one only.**

Married	1
Common-law relationship	2
Separated/Divorced	3
Widowed	4
Single	5

4. What is your highest educational preparation in nursing? **Answer one only.**

Diploma - RN	1
Diploma - RPN	2
BScN / BN	3
MScN / MN	4
PhD	5

Other (Specify) ______________________________

5. What is your highest educational preparation **other** than in nursing? **Answer one only.**

Certificate 1

Diploma 2

Degree 3

Masters 4

PhD 5

Other (Specify) ____

6. How long have you been working as a nurse in the mental health field? (Do not count years as a student.) ________ (years)

7. In what area of mental health nursing are you currently working? **Answer one only.**

Geriatrics 1

Adult 2

Child and Adolescent 3

Forensic 4

Group Therapy 5

None 6

Other (Specify) ____

8. How long have you been working in the above area? (If you chose "none" please answer with a "0") ________ (years)

9. What is your area of specialty? **Answer one only.**

Geriatrics 1

Adult 2

Child and Adolescent 3

Forensic 4

Group Therapy 5

None 6

Other (Specify) ____

10. What areas of mental health nursing have you worked in the past? **Answer all that apply.**

Geriatrics	1
Adult	2
Child and Adolescent	3
Forensic	4
Group Therapy	5
None	6

Other (Specify) ____________________

11. In what type of nursing position are you currently working in? **Answer as many as apply.**

Permanent	1
Temporary	2
Casual	3
Contract	4
Self-employed	5

Other (Specify) ____________________

12. How much do you work? **Answer one only.**

Part-time (less than 37.75 hours per week)	1
Full time (37.75 - 44 hours per week)	2
More than full-time	3

13. What is your place of employment ? **Answer as many as apply.**

Acute Care Hospital	1
Provincial Institution	2
Nursing Home or Continuing Care Facility	3
Clinic or Physician's Office	4
Private Agency	5
Home Care	6
Community or Outpatient Program	7
University or College	8
School	9
Private Practice	10

Other (Specify) ____________________

____

14. What is the title of your position? **Answer as many as apply.**

Staff Nurse (RN / RPN)	1
Charge Nurse / Team Leader	2
Head Nurse / Assistant Head Nurse	3
Manager / Assistant Manager	4
Director / Assistant Director	5
Administrator	6
Educator / Clinical Specialist	7
Professor, Assistant Professor or Associate Professor	8
Consultant	9

Other (Specify) ____________________

15. In what geographical location do you work? **Answer one only.**

City (over 500,00)	1
City (under 500,00)	2
Town	3
Village/Hamlet	4
Rural Area	5

16. For each of the following, please indicate how important you would rate the statements about PROFESSIONAL BOUNDARIES. Answer on a scale of 1 to 5 where 1 means "not important at all" and 5 means "very important."

Professional Boundaries are defined by the AARN as those lines which separate therapeutic behaviour of a professional from behaviour which whether well intentioned or not, could detract from achievable health outcomes or patients and clients receiving nursing care.

How important is it to:	**Not Important At All**				**Very Important**
a. Understand what professional boundaries are.	1	2	3	4	5
b. Understand my own personal boundaries.	1	2	3	4	5
c. Know my professional code of ethics.	1	2	3	4	5
d. Establish professional boundaries with patients.	1	2	3	4	5
e. Maintain professional boundaries with patients.	1	2	3	4	5

17. For each of the following, please indicate how strongly you disagree or agree with the statements about GIFT GIVING. Answer on a scale of 1 to 5 where 1 means "strongly disagree" and 5 means "strongly agree."

There are times when it is appropriate to:	**Strongly Disagree**				**Strongly Agree**
a. Lend money to patients/clients.	1	2	3	4	5
b. Borrow money from patients/clients.	1	2	3	4	5
c. Accept gifts under $20 from patients/clients.	1	2	3	4	5
d. Accept gifts over $20 from patients/clients.	1	2	3	4	5
e. Give a gift of under $20 to a patient/client.	1	2	3	4	5
f. Give a gift of over $20 to a patient/client.	1	2	3	4	5

18. For each of the following, please indicate how often the statements about GIFT GIVING reflect your behaviour while providing patient care. Answer on a scale of 1 to 5 where 1 means "never" and 5 means "always."

There are times when I have:	**Never**	**Rarely**	**Some-times**	**Often**	**Always**
a. Lent money to a patient/client.	1	2	3	4	5
b. Borrowed money from a patient/client.	1	2	3	4	5
c. Accepted a gift of under $20 from a patient/client	1	2	3	4	5
d. Accepted a gift of over $20 from a patient/client.	1	2	3	4	5
e. Given a gift of under $20 to a patient/client.	1	2	3	4	5
f. Given a gift of over $20 to a patient/client.	1	2	3	4	5

19. For each of the following, please indicate how strongly you disagree or agree with the statements about PERSONAL DISCLOSURE. Answer on a scale of 1 to 5 where 1 means "strongly disagree" and 5 means "strongly agree."

There are times when it is appropriate to:	**Strongly Disagree**				**Strongly Agree**
a. Use first names with patients/clients.	1	2	3	4	5
b. Discuss your religious beliefs with patients/clients.	1	2	3	4	5
c. Discuss your own interpersonal issues with patients/clients.	1	2	3	4	5
d. Discuss your own mental health issues with patients/clients.	1	2	3	4	5
e. Curse or swear during interactions.	1	2	3	4	5
f. Provide your home phone number to patients/clients.	1	2	3	4	5
g. Provide your home address to patients/clients.	1	2	3	4	5

20. For each of the following, please indicate how often the statements about PERSONAL DISCLOSURE reflect your behaviour while providing patient care. Answer on a scale of 1 to 5 where 1 means "never" and 5 means "always."

There are times when I have:	**Never**	**Rarely**	**Some-times**	**Often**	**Always**
a. Used first names with patients/clients.	1	2	3	4	5
b. Discussed my religious beliefs with patients/clients.	1	2	3	4	5
c. Discussed my own interpersonal issues with patients/clients.	1	2	3	4	5
d. Discussed my own mental health issues with patients/clients.	1	2	3	4	5
e. Cursed or sworn during interactions.	1	2	3	4	5
f. Provided my home phone number to patients/clients.	1	2	3	4	5
g. Provided my home address to patients/clients.	1	2	3	4	5

21. For each of the following, please indicate how strongly you disagree or agree with the statements about CONFIDENTIALITY. Answer on a scale of 1 to 5 where 1 means "strongly disagree" and 5 means "strongly agree."

There are times when it is appropriate to:	**Strongly Disagree**				**Strongly Agree**
a. Ask a patient/client to keep a confidence from the treatment team.	1	2	3	4	5
b. Keep a confidence regarding others in the patient's/client's life from the treatment team at the request of a patient/client.	1	2	3	4	5
c. Keep a confidence regarding the patient/client from the treatment team at the request of a patient/client.	1	2	3	4	5
d. Keep a confidence regarding the safety of the patient/client from the treatment team at the request of a patient/client.	1	2	3	4	5
e. Keep a confidence regarding the safety of others in the patient's/client's life from the treatment team at the request of a patient/client.	1	2	3	4	5

22. For each of the following, please indicate how often the statements about CONFIDENTIALITY reflect your behaviour while providing patient care. Answer on a scale of 1 to 5 where 1 means "never" and 5 means "always."

There are times when I have:	**Never**	**Rarely**	**Some-times**	**Often**	**Always**
a. Asked a patient/client to keep a confidence from the treatment team.	1	2	3	4	5
b. Kept a confidence regarding others in the patient's/client's life from the treatment team at the request of a patient/client.	1	2	3	4	5
c. Kept a confidence regarding the patient/client from the treatment team at the request of a patient/client.	1	2	3	4	5
d. Kept a confidence regarding the safety of the patient/client from the treatment team at the request of a patient/client.	1	2	3	4	5
e. Kept a confidence regarding the safety of others in the patient's/client's life from the treatment team at the request of a patient/client.	1	2	3	4	5

23. For each of the following, please indicate how strongly you disagree or agree with the statements about DUAL RELATIONSHIPS. **(Dual relationships occur when the nurse enters into an interpersonal relationship along with the therapeutic or helping relationship).** Answer on a scale of 1 to 5 where 1 means "strongly disagree" and 5 means "strongly agree."

There are times when it is appropriate to:

	Strongly Disagree				**Strongly Agree**
a. Provide care (assessment or treatment services) to your friends or family members.	1	2	3	[✓ 4]	5
b. Comment to patients/clients on their physical attractiveness.	1	2	3	4	5
c. Develop a friendship with a current patient/client.	1	2	3	4	5
d. Develop a friendship with a patient/client following discharge.	1	2	3	4	5
e. Participate in recreational or social activities outside of work with a current patient/client.	1	2	3	4	5
f. Participate in recreational or social activities outside of work with a patient/client following discharge.	1	2	3	4	5
g. Invite a current patient/client to your home.	1	2	3	4	5
h. Invite a patient/client to your home following discharge.	1	2	3	4	5
i. Go on a date with a current patient/client.	1	2	3	4	5
j. Go on a date with a patient/client following discharge.	1	2	3	4	5
k. Have a sexual relationship with a current patient/client.	1	2	3	4	5
l. Have a sexual relationship with a patient/client following discharge.	1	2	3	4	5

24. For each of the following, please indicate how often the statements about DUAL RELATIONSHIPS reflect your behaviour while providing patient care. Answer on a scale of 1 to 5 where 1 means "never" and 5 means "always."

There are times when I have:	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
a. Provided care (assessment or treatment services to my friends or family members.	1	2	3	4	5
b. Commented to patients/clients on their physical attractiveness.	1	2	3	4	5
c. Developed a friendship with a current patient/client.	1	2	3	4	5
d. Developed a friendship with a patient/client following discharge.	1	2	3	4	5
e. Participated in recreational or social activities outside of work with a current patient/client.	1	2	3	4	5
f. Participated in recreational or social activities outside of work with a patient/client following discharge.	1	2	3	4	5
g. Invited a current patient/client to my home.	1	2	3	4	5
h. Invited a patient/client to my home following discharge.	1	2	3	4	5
i. Gone on a date with a current patient/client.	1	2	3	4	5
j. Gone on a date with a patient/client following discharge.	1	2	3	4	5
k. Had a sexual relationship with a current patient/client.	1	2	3	4	5
l. Had a sexual relationship with a patient/client following discharge.	1	2	3	4	5

25. For each of the following, please indicate how strongly you disagree or agree with the statements about PERSONAL SPACE. Answer on a scale of 1 to 5 where 1 means "strongly disagree" and 5 means "strongly agree."

There are times when it is appropriate to:	**Strongly Disagree**				**Strongly Agree**
a. Use therapeutic massage with a patient/client.	1	2	3	4	5
b. Hold a patient's/client's hand.	1	2	3	4	5
c. Put your arm around a patient/client.	1	2	3	4	5
d. Hug a patient/client.	1	2	3	4	5
e. Kiss a patient/client.	1	2	3	4	5

26. For each of the following please indicate how often the statements about PERSONAL SPACE reflect your behaviour while providing patient care. Answer on a scale of 1 to 5 where 1 means "never" and 5 means "always."

There are times when I have:	**Never**	**Rarely**	**Some-times**	**Often**	**Always**
a. Used therapeutic massage with a patient/client.	1	2	3	4	5
b. Held a patient's/client's hand.	1	2	3	4	5
c. Put my arm around a patient/client.	1	2	3	4	5
d. Hugged a patient/client.	1	2	3	4	5
e. Kissed a patient/client.	1	2	3	4	5

27. For each of the following please indicate how often the statements about NURSE/ PATIENT RELATIONSHIPS reflect your behaviour while providing patient care. Answer on a scale of 1 to 5 where 1 means "never" and 5 means "always."

	Never	**Rarely**	**Some-times**	**Often**	**Always**
28. Have you ever felt that you were the only one who understood a certain patient/client?	1	2	3	4	5
29. Have you ever felt that certain staff members were too critical of one of your patients/clients?	1	2	3	4	5
30. Have you ever felt that other staff members were jealous of your relationship with a certain patient/client?	1	2	3	4	5

		Never	**Rarely**	**Some-times**	**Often**	**Always**
31.	Have you arrived early or stayed late to be with one of your patients/clients for a longer period of time?	1	2	3	4	5
32.	Have you ever received feedback that you get too involved with patients/clients?	1	2	3	4	5
33.	Have you ever acted on sexual feelings that you have for a patient/client?	1	2	3	4	5
34.	Have you ever had a sex with a patient/client?	1	2	3	4	5

35. Have you received any education in the areas of professional boundaries?

No .... 1 (If **NO** go to question 37)
Yes .... 2 (If **YES** go to question 36)

36. Where did you receive information about professional boundaries? **Circle as many as apply.**

In a Diploma Program 1
In a Baccalaureate Program 2
In a Graduate Program 3
Through my Workplace 4
Through my Professional Association 5
Through Conferences or Workshops 6
Other (Specify) ____

____

37. How interested are you in increasing your knowledge of professional boundaries?

Very 1
Somewhat 2
A Little 3
Not at All 4

Comments:

Thank you for answering these questions.

You will remain anonymous and your answers will be kept strictly confidential.

As the results of this study become available, individuals will never be identified. Only group averages and other general statistics will be made public.

Please put this questionnaire in the postage-paid addressed envelope and mail it.

Thank you.